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What Should We Do When Cure Is Not Possible?

aid in dying  end-of-life options

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MedChi’s 2017 Legislative Agenda & Commentary
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This issue of *Maryland Medicine* looks at the various options for physicians and patients to consider if cure is not possible.

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What Would Sir William Osler Do?

I have just returned from the American Medical Association (AMA) Interim Meeting in Orlando, Florida. Every time I go to one of these meetings, I am always impressed by the quality and enthusiasm of the attendees. There are representatives from every state and medical specialty. Imagine 1,000 physicians in a room arguing medical policy. Yes, sometimes it is like herding cats, but we were surprisingly united in our desire to provide the best in patient care and ensuring patients’ continued access to that care. Following the recent election, the assembled physicians were extremely concerned how the new administration would approach health care and how the Affordable Care Act (ACA), MACRA, and other programs would change. We were assured (warned?) that MACRA (Medicare Access and CHIP Reauthorization Act) is independent of the ACA and would require a much different review and process than the ACA. The AMA was in contact with both campaigns before the election, and was initiating the relationships necessary to provide a smooth transition. With the results, I participated in crafting a resolution from Reference Committee B (Legislation) reiterating the AMA’s strong and long standing policies on access to care and providing the highest quality of care. The House approved our resolution overwhelmingly, demonstrating the AMA’s strong commitment to quality care.

Our AMA and its physicians are committed to trying to make life better for all of us. It takes a lot of time and effort out of everyone’s busy schedule to be part of the process to help shape the future of medicine. Here in Maryland, each of us can do a little bit to make life a little brighter for all of us. Show up at a hospital meeting and participate in a committee. Do the same for your county medical society. It doesn’t really take a lot of work to be involved. You will probably find that it is rewarding. Don’t just grumble. Get out and do something about it.

The results of our recent and momentous election shocked some of us and delighted others. We are now trying to adjust to the thought of a Trump presidency. I don’t doubt things will change in the medical arena, on the national or the state level. What will happen to the Waiver? What will happen to Medicaid funding? What will happen with Tort Reform? These are unanswered questions at this time.

We do need to keep one thing in mind. We are physicians. We take care of patients. There will always be medicines to prescribe, shots to give, fractures to set, lifestyle changes to teach, and families to console. We may make more money. We may make less. But we can’t lose sight of the reason we came into this noble profession: to touch the lives of our patients, to relieve the suffering, and to do what we can to make their lives easier and more fulfilling. It’s what Sir William Osler would want us to do.

I want to note the retirement of Stephen Johnson, our long-serving legal counsel at MedChi. Steve has been with us for as long as I can remember, and has provided wise and sage counsel through many crises. He has stepped in and stepped up each and every time with grace and aplomb, and guided us through all kinds of difficulties. Ever unflappable, he has always been there to cut through the BS and get it right. While he is not going completely off into the sunset and will be around for special projects (it’s called “Institutional Memory”), I wanted everyone to know and appreciate the value he has provided us for so many years.

This holiday season, I want to wish each and every one of you peace, happiness, and strength for the upcoming New Year.

How to Get Involved in MedChi’s Legislative Activities

Become an Effective Advocate

For members seeking to become better advocates for physicians, patients, and the public health, visit www.medchi.org/Law-and-Advocacy/Get-Involved and log in to access information on the following:

- American College of Physicians Statement of Principles on the Role of Governments in Regulating the Patient-Physician Relationship
- Communicating with Government Officials
- Discussing Political Issues with Patients
- How to Submit a MedChi Resolution
- The Do’s and Don’ts of Effective Communication

Serve as MedChi Physician of the Day

MedChi is proud to staff the First Aid Room in Annapolis during the legislative session. The First Aid Room, located in the basement of the State House, is equipped with oxygen, hospital bed, wheelchair, crutches, thermometers, stethoscope, and blood pressure cuff. A nurse is on the premises every day and rarely do you encounter anything more than colds or the flu, so the Physician of the Day can spend some time in the Chambers observing the Senate and House conducting the work of the state government. There are also a variety of over-the-counter medications provided including aspirin, cough and cold preparations, and antacids. Volunteers are asked to bring their own prescription pads in the event treatment requires prescribed medication.

Volunteers who wish to speak with their senator or delegates while serving as the Physician of the Day will be provided with briefing materials on specific MedChi agenda items. A schedule of hearings and meetings that deal with health-related issues is posted in the First Aid Room. Volunteers are encouraged to sit in on these
These types of problems may interfere with the safe practice of medicine, or the effective operation of your practice or institution, and have the potential to result in legal and disciplinary actions, which may even affect licensure status. Most importantly, these issues can be addressed through early and appropriate assessment and treatment. Do not wait to seek assistance, because the greater the delay the higher the risks.

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For a confidential consultation for you or a colleague who may benefit from our help, please call 800-992-7010 or 410-962-5580.

We need your support! Please consider making a tax-deductible contribution to the Maryland Physician Health Program. For more information visit www.healthymaryland.org or call us at 800-992-7010 or email phpinfo@medchi.org.

Call MPHP First!
Increasing diabetes rates are a primary driver of Maryland’s rising health care costs. In 2012, diabetes alone cost families and the U.S. economy more than $245 billion, taking into account direct costs (e.g., health care services and prescriptions) and indirect costs (e.g., absenteeism, lost productivity). MedChi, The Maryland State Medical Society, which represents more than 8,000 Maryland physicians and their patients, commissioned The Hilltop Institute at the University of Maryland, Baltimore County (UMBC), to conduct a study (Briefing Report: An Examination of Service Utilization and Expenditures among Adults with Diabetes Enrolled in Maryland’s Medicaid Managed Care Program) providing an estimate of both the extent of diabetes in Maryland Medicaid enrollees and the likely financial impact of this largely preventable disease on taxpayers.

Diabetes is a serious chronic disease that now affects 29 million Americans (Figure 1), including more than 610,000 Marylanders (about 10 percent of the state’s population). Another 567,000 Marylanders have been diagnosed with pre-diabetes, and national trends indicate that up to one-third of all adults may have undiagnosed pre-diabetes. People with diabetes have a heightened risk of developing additional health problems and complications, such as heart disease, blindness, amputations, stroke, and kidney failure. While data on rates of diabetes and associated costs have been calculated nationally, no clear assessment of cost data had been gathered for state taxpayer-funded, public health care programs in Maryland until now. Hilltop’s study assesses the impact of diabetes on HealthChoice, Maryland’s Medicaid managed care program, over a two year period. HealthChoice plays a major role in providing health care coverage for Marylanders with diabetes. The Hilltop study suggests what has long been suspected: Diabetes within the Maryland Medicaid program is costly to taxpayers. Medicaid annual spending per enrollee with diabetes ($24,387) is more than double the spending per enrollee without diabetes ($10,880). HealthChoice spent more than $471 million treating people with diabetes in 2014 for hospitalizations, doctor visits, and prescriptions.

The actual cost of diabetes to the entire Maryland Medicaid program is likely understated, since this study did not account for the costs incurred by Medicaid enrollees younger than age 35, enrollees in the fee-for-service program, such as dual-eligible beneficiaries and adults living in long-term care facilities, or enrollees with less than twelve months of enrollment in the HealthChoice program. As Maryland’s youngest generation is diagnosed with escalating rates of diabetes and pre-diabetes, these costs will only increase. The burden to our patients, their families, and state taxpayers will continue to intensify, putting strain on Medicaid funding, enrollment, and perhaps even the quality of care provided.

The Hilltop study focused on enrollees aged thirty-five through sixty-four years with twelve months of continuous enrollment in HealthChoice. The following key points came to light upon examination of the 2014 data:

- More than one quarter of expenditures are attributable to people with diabetes.
- Those with diabetes were more likely to be admitted to a hospital.
- Maryland Medicaid enrollees experience higher rates of diabetes than non-enrollees.
- Disparities exist.
- The disease burden in Central Maryland is particularly high.
- Younger people are being diagnosed with diabetes.
- More women than men live with diabetes.

If this study is any indication, the future cost of diabetes to both Medicaid and private insurance will be difficult for our health care system to absorb, making premium costs even more unbearable for most families and potentially eroding taxpayer-funded safety net programs.

A Prescription for Change:
Together, we must do all we can to help prevent, diagnose, and effectively treat diabetes or it will greatly increase health care expenditures and the taxpayer funds needed to support the Medicaid program. MedChi and its member physicians call upon all Marylanders to follow our prescription for change.
President’s Message ...

Continued from page 5

meetings, as well. Please consider taking a day to help with this fun and interesting project. All members with active licenses are encouraged to participate. If you are interested, please contact Stephanie Wisniewski at 410. 539.0872, ext. 6001. The Legislative Session runs from Wednesday, January 11, through Monday April 10, 2017.

Participate in Physician’s House Call on Annapolis

Each year during the legislative session, MedChi’s component medical societies assemble at MedChi’s Annapolis office to hold their annual legislative meetings. During your legislative day in Annapolis, you will have the opportunity to meet with the legislators from your district and observe the session proceedings of the House or Senate. Participants are provided with talking points on issues and bills important to MedChi, as well as MedChi’s legislative agenda and legislative newsletter. Please consider signing up for the Physician’s House Call.

To learn more about the General Assembly of Maryland, and check the status of legislation, committee work, and more, visit www.mgaleg.maryland.gov.

CEO’s Message ...

Continued from page 7

For Individuals and Families:

- Learn about diabetes and pre-diabetes and see your doctor for regular check-ups and screenings.
- Maintain a healthy weight by eating foods that are low in fat, sugar, and calories. Limit your portion sizes.
- Engage in thirty minutes of physical activity at least five days a week.
- Drink water instead of sugary drinks.
- Advocate for federal, state, and local policies to address the growing diabetes epidemic.
- If you already have diabetes, follow the prescriptions above, take your medication, and tell your doctor about sores that don’t heal or if you have trouble with your eyesight.

For Health Insurers and Providers:

- Educate providers about effective diabetes and pre-diabetes prevention, screening, and early detection, as well as treatment programs and referrals.
- Ensure patient access to and provider reimbursement for pre-diabetes and diabetes prevention services and screenings, self-management education, and treatment services provided by medical and non-medical providers and specialists
- Remove sugary drinks from health care facilities.
- Dedicate a substantial proportion of community benefit funding to building healthy communities.
- Advocate for federal, state, and local policies to address the growing diabetes epidemic.

For Cities and Counties:

- Implement diabetes prevention recommendations (e.g., develop walkable communities, healthy transportation).
- Ensure access to clean, free drinking water in public places.
- Conduct public education campaigns about products known to contribute to diabetes and promote consumption of healthy products.
- Pass diabetes prevention policies recommended by national and state health authorities; require sugary drink warning labels to be displayed at the point of purchase; and reform restaurant children’s menus so that they include healthier drinks as the default.
- Establish local taxes on sugary drinks, designating funds for programs to prevent, detect, and treat diabetes.

For State Lawmakers in Annapolis:

- Require public and private health insurers to cover early screening and detection programs, diabetes management support services and equipment, and diabetes prevention services, including those provided by medical and non-medical providers.
- Conduct public education campaigns about products known to contribute to diabetes and promote consumption of healthy products including water.
- Pass diabetes prevention policies recommended by national and state health authorities; require sugary drink warning labels to be displayed at the point of purchase; and reform restaurant children’s menus.
- Work with local school systems to increase the amount of time allotted to physical education and physical activity during the school day.
- Establish a state tax on sugary drinks, designating funds for programs to prevent, detect, and treat diabetes and other diet-related illnesses.

The Institute of Medicine, the Centers for Disease Control, MedChi, and other experts agree on the way forward. Taxpayers bear the brunt of Medicaid’s increasing diabetes-related costs. The actions above must be a state priority. Maryland cannot afford the status quo.

References


The full text of MedChi’s report, The Cost of Diabetes to Maryland Taxpayers: A Prescription for Change, is available at http://www.medchi.org/News-and-Publications/Surveys. For a complete list of references, please contact scarey@montgomerymedicine.org.
I had to miss the AMA November interim meeting in Orlando because of a temporary infirmity. I am a delegate and I like to go, and I like to participate in the warp and woof of the fabric that is organized medicine. It feels a lot like an amalgam of a political convention mixed with the Chicago stockyards, but it’s interesting, often productive, and fun. So, while my colleagues were feeling useful in Orlando (admit it, colleagues, you also liked bumping into Donald Duck and hoped to visit Tomorrowland in a spaceship shaped tram), I was getting grumpier and more gloomy. I was a bit caustic and sharp tongued to those I shouldn’t have been and gave terse one word answers or, so help me, grunts, to nice people asking simple questions of me. I felt a bit depressed and a bit anxious and a bit out of the loop. I was also in pain, which didn’t help my mood one bit, but I adjusted to that as a temporary norm pretty quickly. This wasn’t anything very serious, nor did it promise to be chronic and drawn out. Given a bit of luck, it could be fixed with a curette and an arthroscope and that would be it, along with a bit of physical therapy, a tick and a prayer.

But I was “off” and I knew it, and I was sure those around me knew it. In fact, I was sure those around me wanted to be anywhere but around me. My demeanor was punctuated with short, clipped sentences and vague sounds of complaint. I was a bit in pain, and in the best spirit of “piling on” I contracted some viral URI that made me sound like I had marbles in my mouth combined with a frog farm in my larynx…a demented Marlon Brando Godfather.

Many physicians have written about being a patient. We are, all of us, at some time or other, patients, of course. The general theme of most writings is that being a patient is a humbling experience for the most part. It’s not just the symptoms that make us ornery and somewhat demanding, although the droning experience of pain does a good job of making us both. Being sick, being a patient, transports us into a different state of being…often unproductive, vulnerable, fearful. It makes us somewhat irrational, at least insofar as it strips us of our normal veneer of sociability and automatic behaviors that propel us, more or less effortlessly, through the day. It demands our attention in one way or another, and leaves us with less to deal with the world around us successfully. It takes energy to deal with illness, and that portion of energy that is usually reserved for our interface with the world around us is drained by the same measure.

This episode reminded me that being a patient is a tough business. Perhaps I will retain the memory of being under the weather. Although being kind to and understanding of patients is drilled into us from the time we enter medical school, it bears repeating over and over. Being a patient is a tough job, and humiliating at times. I need to be more mindful of this in my dealings. But I still wish I had gotten to meet Goofy!

This issue of Maryland Medicine is devoted to a difficult and increasingly visible topic…the role of the physician in the process of aid in dying. If you attended some of the meetings around the state and at MedChi, you are aware that this discussion is taking place in the halls of medicine, and the chambers of the state legislatures. It is being spoken about much more openly, and questions will be asked of many of us by our patients about aid in dying. We are grateful to Michael Strauss, MD, and Hank Willner, MD, and the other contributors for a serious, in depth, comprehensive, and sober look at several sides of this difficult issue. I can assure you that they worked very diligently on this for a long time to bring you this information. They and their collateral authors have done us a service. I hope you are moved to participate in the discussion through your letters to Maryland Medicine in the coming months. Thank you.
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Introduction: What Can You Do and What Should You Do in End-of-Life Care?

Michael J. Strauss, MD, MPH, and Hank Willner, MD

This issue of Maryland Medicine focuses on several aspects of decision-making at the end of life. Its genesis can be traced to the statewide and national discussion of a controversial topic that is referred to by many names—physician aid in dying, death with dignity, physician-assisted suicide—and that has been addressed recently by both the MedChi House of Delegates and the state legislature. To cover this topic appropriately, we have invited several local and national experts to examine many of the issues and decisions that physicians and their patients face near the end of life.

Michael J. Strauss, MD, MPH, a Maryland internist and advocate for physician aid in dying, Terri L. Hill, MD, a plastic surgeon and member of the Maryland House of Delegates, begin the discussion with an overview of the arguments supporting physician aid in dying. Ira Byock, MD, Executive Director for the Institute for Human Caring, Professor at the Geisel School of Medicine at Dartmouth College and Past President of the American Academy of Hospice and Palliative Medicine, provides his perspective on why physician-assisted suicide is wrong.

Hank Willner, MD, Chief Medical Director at Holy Cross Home Care and Hospice and a member of the Maryland State End of Life Council, reviews the increasingly important role of palliative care. Puneeta Khurana, MD, Rachel Diamond, MD, and Timothy Quill, MD, of the University of Rochester discuss the often poorly understood practices of palliative sedation and voluntarily stopping eating and drinking (VSED). Dr. Quill is recognized internationally as an expert in these fields. Randy Schisler, MD, the Site Director of Palliative Care and Medical Chair of Ethics at Carolinas Healthcare Systems NorthEast in Concord, North Carolina, and Terri Vickey, MSN, a palliative care consultant at a tertiary hospital in North Carolina, review the topic of decision-making capacity. And Dan Morhaim, MD, an emergency medicine physician and member of the Maryland House of Delegates, reviews how patients can plan for the end of life.

Also in this issue, we present the MedChi legislative agenda for the upcoming Maryland general assembly, along with commentary by Stephen J. Rockower, MD.

We hope you enjoy the articles. We believe that they will help advance the policy discussion in Annapolis and in other state capitals throughout the country and will enhance the quality of medical care at the end of life.
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. During the 2017 General Assembly Session, MedChi shall work on the following objectives:

**AS AN ADVOCATE FOR PATIENTS**

**Defend the Scope of Medical Practice so Patients Are Seen by a Physician:** MedChi will fight to ensure that all patients have access to physicians and that physician extenders have appropriate training and physician oversight. It is critical that patients have access to physicians and that non-physicians do not use increased demand for services to inappropriately increase their scope of practice.

**Protect Medicaid and the Uninsured:** MedChi will work to incentivize physician participation and to protect the integrity of the Medicaid program, including continuing to advocate for full restoration of E&M payment to Medicare rates for all physicians who serve Medicaid enrollees.
AS AN ADVOCATE FOR PHYSICIANS

DEFEND PHYSICIAN RIGHTS: MedChi will work to protect Maryland’s physicians by:

• Monitoring the regulatory and disciplinary actions of the Board of Physicians;
• Addressing delays in obtaining CDS licenses from the Department of Health & Mental Hygiene;
• Protecting and enhancing the integrity of the Prescription Drug Monitoring Program and its use by physicians;
• Preventing workers’ compensation insurers from limiting a physician’s right to dispense medications to an injured worker;
• Supporting continued efforts to address network adequacy and formulary practices; and
• Working to further standardize credentialing requirements.

STRENGTHEN MEDICAL LIABILITY REFORM: MedChi will continue to strongly oppose trial lawyer attempts to increase the “cap” on damages in medical malpractice cases and to abolish the defense of contributory negligence; support efforts to extend the “cap” on damages to physician assistants; establish a pilot project for specialized health courts and to limit repeated continuances in medical malpractice cases; and otherwise work to protect and strengthen the legal liability environment for physicians in Maryland.

ENHANCE PHYSICIAN PAYMENT AND INSURANCE REFORM: MedChi will continue its efforts to improve Maryland’s payment climate by working to ensure that gain-sharing and other payment mechanisms for system reform are developed through a stakeholder process that includes broad physician participation and that will have a positive impact on physicians.

AS AN ADVOCATE FOR PUBLIC HEALTH

PROTECTING MARYLAND’S CHILDREN: MedChi will support initiatives to protect children including initiatives to:

• Address childhood obesity including efforts to reduce the consumption of sugary beverages and other unhealthy food choices;
• Increase HPV immunization rates for children at the CDC recommended ages;
• Strengthen child safety seat and young driver laws;
• Address homelessness, affordable housing and its impact on public health; and
• Require schools to provide parents with information about the risks of skin cancer and strategies and behaviors to reduce the risk.

ENDING HEALTH DISPARITIES: MedChi will continue its support of legislative and regulatory initiatives to reduce health disparities.

MAKING MARYLAND A TOBACCO FREE STATE: MedChi will advocate for continued increases in the Tobacco Tax in order to discourage smoking and to help fund Medicaid and restore enhanced E&M payment for all physicians serving Medicaid enrollees. MedChi will also support legislation prohibiting the sale of tobacco products by businesses which provide health care or dispense medications.

DRUG TRANSPARERNCY: MedChi will support initiatives that address drug price transparency for name brand and generic pharmaceutical manufacturers and pharmacy benefit managers.

ANTIBIOTIC RESISTANCE: MedChi will support initiatives that combat antimicrobial resistance by curbing routine use in food production.

HOW DO I HELP CREATE POSITIVE LEGISLATIVE REFORM FOR PATIENTS, PHYSICIANS, AND THE PUBLIC HEALTH?

JOIN MEDCHI and your local component medical society at www.medchi.org.

JOIN YOUR COMPONENT SOCIETY in Annapolis by attending “Physician House Call on Annapolis” lobbying days for an opportunity to discuss important issues with your legislators. RSVP by emailing swisniewski@medchi.org.

TAKE ADVANTAGE OF OPPORTUNITIES to discuss important issues with legislators.

STAY INFORMED on legislative issues affecting your practice and profession by reading MedChi’s weekly e-newsletter, MedChi News, the quarterly magazine, Maryland Medicine, and visiting www.medchi.org. All members are welcome to attend the legislative council meetings.

EMAIL OR PHONE your delegates when MedChi or your component sends you a legislative alert about a bill. Visit the Legislative Action Center at www.medchi.org. Remember to donate to the MMPAC and help keep physician-friendly legislation in Annapolis.

TESTIFY AT A COMMITTEE HEARING. Contact your component medical society for details.

VOLUNTEER TO SERVE. As Physician of the Day in the Maryland State House during the legislative session. Email swisniewski@medchi.org.
MedChi's 2017 Legislative Goals for Maryland Physicians and Our Patients

Stephen J. Rockower, MD

The MedChi legislative process has been strong as we prepare for the 2017 legislative season. MedChi’s House of Delegates passed numerous resolutions at the meeting in September, and we have continuing resolutions carried over from previous years. MedChi continues to advocate for physicians, their patients, and the public health. With the recent election, there are certainly concerns as to the future direction of the Waiver, and our Medicaid funding. We will constantly monitor and advocate on behalf of physicians.

Liability

One of our priorities has always been concerns about Tort Reform and Malpractice. The Trial Lawyers, now known as the “Maryland Association for Justice,” have been advocating for years to turn over Maryland’s long standing cap on non economic damages (sometimes known as “pain and suffering”). This cap, carefully negotiated more than fifteen years ago, has kept insurance rates stable and rises each year by a specified amount. Each year, efforts have been made to triple the cap or raise it for “catastrophic injuries.” How that would be defined is certainly a matter of conjecture. We will continue to oppose such efforts, and to redefine the meaning of economic damages.

In addition, we will be advocating for a change in the law to include coverage for Physician’s Assistants (PAs) to come under the cap. When the law was adjusted a few years ago, the PAs somehow were left out, so they have an unlimited cap. The unlimited cap would flow through to the employer, the physician. It is an oversight to leave them out of the protections given to physicians, Nurse Practitioners, and other advanced practice providers.

We will also be advocating to strengthen the “Apology Bill,” which allows physicians to discuss untoward results with patients and families, and allows hospitals to conduct reviews without having such information being used as weapons in court. These Patient Safety Intervention Programs would be helpful to improve outcomes throughout the health care delivery process.

We continue to advocate for the concept of “Health Courts,” in which trained, impartial judges would be in charge of the outcomes of the cases, not emotionally swayed juries. There have been previous efforts in this regard, and we will continue to promote the concept.

Scope of Practice

Health care providers should only practice what they are trained and are competent to do. There have been discussions over the years to allow alternative providers to practice what has always been considered the practice of Medicine. We have seen the Naturopaths, Podiatrists, and Lay Midwives take on more and more responsibilities that are apparently above their training level. This year’s discussion centers on optometrists’ desire to not only refract eyes, but to prescribe eyedrops and oral medications and perform surgical procedures. They contend this is an “access” issue, but 90 percent of Maryland’s population lives within ten miles of an ophthalmologist. We will contest this expansion vigorously.

Public Health

Prices of drugs continue to be in the news and of significant public concern. Both brand name drug and generic prices have skyrocketed in recent years. MedChi’s House of Delegates has passed resolutions to require manufacturers and Pharmacy Benefit Managers (PBMs) to be more transparent in their pricing to allow patients to pay a fair price for their care.

We continue to advocate to restrict high antibiotic use in farm animals to prevent the ongoing increase in antibiotic resistance. We also continue to advocate for increased payment for Medicaid patients’ E&M visits. Last year, we were able to convince Governor Hogan to increase payments to 94 percent of Medicare. With the results of the recent national election, much of the funding structure of our Waiver System may be in flux. We continue to advocate and monitor any changes that would negatively impact our system.

As always, we need your help. Participate in the weekly Legislative Committee meetings. If you can’t drive to MedChi, you should be able to participate in meetings via a Zoom connection. We want your help! Plan to come to Annapolis for your county’s Advocacy Day. Numbers are important! Spend a day as “Doctor of the Day.” It is easy, and you get to be recognized on the floor of the House or Senate (plus you get free parking for the day!). Send emails or phone your legislators when Legislative Alerts are distributed. These are very important ways everybody can help.

Remember, “If you are in Medicine, you are in Politics!”
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ACCREDITATION STATEMENT
Activities were planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of MedChi, The Maryland State Medical Society, and The University of Maryland School of Pharmacy. MedChi is accredited by the ACCME to provide continuing medical education for physicians.
Physician Aid in Dying — What is it?

End-of-life care, having seen extraordinary progress over recent decades, addresses most of the complex needs of terminally ill patients for whom a cure is not an option (see “When Cure Is Not Possible: The Role of Palliative Care,” page 22). For some, however, suffering continues despite our best efforts.

Physician Aid In Dying (AID)—sometimes termed death with dignity or physician-assisted suicide—refers to a medical practice in which patients with decision-making capacity and a prognosis of six months or less may request, and physicians may prescribe, life-ending medication for self-administration, provided specific requirements are met (see Figure 1). In 1997, Oregon became the first state to legalize the practice, followed by Washington (2009), Montana (2009), Vermont (2013), and California (2015). On November 8, 2016, Colorado voters passed a referendum permitting AID, with implementation likely in December 2016. In November 2016, the Council of the District of Columbia approved a resolution permitting AID. The resolution will become law unless the U.S. Congress intervenes. Most other states are considering, or have considered, similar legislation.

Bills modeled after the Oregon law were introduced in the Maryland General Assembly during 2015 and 2016 legislative sessions and later withdrawn because of inadequate legislative support. In both years advocates and opponents gave testimony at hearings, with physician representation on both sides. Having closely observed and been involved with these proceedings, we recognize that controversy surrounds AID and misinformation confuses the discussion. With the legislation likely to be re-introduced in 2017, we address particular concerns raised by physicians.

Strong Protections For Patients and Providers

To protect potentially vulnerable individuals, the Maryland bill strictly limits patient participation by setting requirements for minimum age, residency, diagnosis, prognosis, and mental capacity. These protections are considerably stronger than protections under current Maryland law permitting palliative sedation and voluntarily stopping eating and drinking (VSED), physician actions that may also hasten patient death (see Figure 2 and article by Khurana et al., page 24). As in states where AID is authorized, physician participation would be voluntary, and those who operate in good faith protected from liability.

No Slippery Slope

In the more than thirty years of combined experience of states authorizing AID, there has been no evidence of abuse or coercion of individuals to elect AID, no expansion of the medical conditions for which AID is allowed, and no lowering of the age requirement.

Benefit for the Few

In Oregon, between 1998, when the law went into effect, and 2016, 1,545 patients have received, and only 991 have taken, a prescription for lethal medication. The low rate is attributed

Figure 1: Key Provisions and Protections of Maryland’s End-of-Life Option Act

<table>
<thead>
<tr>
<th>Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 18 years of age &amp; legal resident</td>
</tr>
<tr>
<td>• “Terminal illness” – within reasonable medical judgment a prognosis likely to result in death within 6 months</td>
</tr>
<tr>
<td>• Capable of self-administering medication</td>
</tr>
<tr>
<td>• Must have capacity</td>
</tr>
<tr>
<td>• Requests aid in dying</td>
</tr>
<tr>
<td>• Initial verbal request</td>
</tr>
<tr>
<td>• Written request (at least 3 days later) with 2 witnesses (one not a family member)</td>
</tr>
<tr>
<td>• 2nd verbal request – at least 15 days after initial request</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attending Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Meets with patient privately to prevent coercion</td>
</tr>
<tr>
<td>• Informs patient of</td>
</tr>
<tr>
<td>• Medical diagnosis and prognosis</td>
</tr>
<tr>
<td>• Feasible alternatives – palliative care and hospice</td>
</tr>
<tr>
<td>• Determines if patient has capacity or refers to mental health professional</td>
</tr>
<tr>
<td>• Informs / counsels patient that he/she may wish to notify next of kin may rescind request at any time</td>
</tr>
<tr>
<td>• Counsels patient about importance of</td>
</tr>
<tr>
<td>• another person present when taking medication</td>
</tr>
<tr>
<td>• not taking medication in public place</td>
</tr>
<tr>
<td>• participating in hospice program</td>
</tr>
<tr>
<td>• preparing an advance directive</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Consulting Physician – corroborate patient’s terminal illness, prognosis, and capacity</td>
</tr>
<tr>
<td>• Psychiatrist / Psychologist – if consulted, determine capacity</td>
</tr>
<tr>
<td>• Nobody is required to participate</td>
</tr>
<tr>
<td>• Attending Physician</td>
</tr>
<tr>
<td>• Consulting Physician</td>
</tr>
<tr>
<td>• Psychiatrist or Psychologist</td>
</tr>
<tr>
<td>• Pharmacist</td>
</tr>
<tr>
<td>• Nursing home, hospital, etc.</td>
</tr>
<tr>
<td>• Patient can rescind at any time</td>
</tr>
<tr>
<td>• Coercing patient is a felony</td>
</tr>
</tbody>
</table>
partly to Oregon's excellent end-of-life care, with more than 90 percent of AID patients enrolled in hospice in the last six months of life. Inability to engage in activities that make life enjoyable, loss of autonomy, and perceived loss of dignity (i.e., incontinence, inability to care for oneself) are the leading concerns given by AID patients. For some patients, having the prescription eases fear over whether the pain of living or process of dying will become too much to bear, even if they never take the medication.

Strong Public Support

Although few people exercise the AID option, multiple surveys, both nationwide and in Maryland, show large support for having it available, with 60 to 70 percent of adults in support and 25 to 35 percent opposed. Fully 65 percent of MedChi’s physicians endorsed changing its position to “support” or “neutral” (see Figure 3). Some have said that most people are only one bad death away from supporting AID laws.

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Voluntarily Stopping Eating and Drinking — VSED (as of 1993)</th>
<th>Palliative Sedation (as of 1999)</th>
<th>Aid in Dying (End-of-Life Option Act of 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Meets with Patient Alone</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>“Cooling Off” Period</td>
<td>No</td>
<td>No</td>
<td>15 days</td>
</tr>
<tr>
<td>Consultation With A Second Physician</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Two Witnesses, One of Whom Cannot Be An Heir</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Two Witnesses, One of Whom Cannot Be A Relative</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Physician to Obtain Mental Health Evaluation if Concern about Patient’s Capacity</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Interpreter, If Necessary, When Physician Meets Independently with Patient to Determine If There Is Correcion</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Neither Suicide Nor Euthanasia Nor Dr. Kevorkian

Suicide is an act of desperation and the product of irrational thinking.

Euthanasia, or “mercy killing,” is the administration of a lethal medical dose to another for the purpose of ending a life. Dr. Jack Kevorkian’s infamous device that helped patients end their lives required substantial assistance, thereby necessitating one person to assist in taking another’s life and meeting the euthanasia definition.

AID is considered an act of acceptance, a rational response to the reality that, despite all therapeutic efforts made in the individual’s battle to live, the disease process has won. To call it suicide disregards the patient’s desire and efforts to live. AID laws not only require that patients self-administer the medication, but also legally defines the act as other than suicide.

Some argue that this is a distinction without a difference, but supporters dispute a claim of moral or legal equivalency between a clinically depressed teenager shooting herself in the head, a Twin Towers occupant on 9/11/01 leaping to avoid being burned alive, and a suffering end-stage cancer patient opting to take life-ending medication.

Some opponents have claimed that aid-in-dying laws have led to an increase in suicide rates (excluding AID cases), citing a recent peer-reviewed study. Such claims are simply wrong. A careful reading of that study shows, and in the body of the paper the authors themselves concede, that after controlling for potential confounding variables, the finding of an effect was “no longer statistically significant.” In addition, a simple graph of Centers for Disease Control and Prevention suicide data (see Figure 4) shows that suicide rates in Oregon and Washington have closely tracked national trends.

Psychiatric Consultation When Needed

Those who provide day-to-day care for the terminally ill—internists, geriatricians, oncologists, and palliative care/hospice physicians—routinely help patients make life-and-death decisions, a process that requires evaluating capacity and depression, and treating appropriately. Therefore, the AID bills that have been before the Maryland legislature have not required psychiatric clearance for patients receiving AID, although both directed physicians to request a psychiatric evaluation if they have questions about the patient’s psychological status or capacity. The bill likely to be introduced in 2017 is expected to have the same provisions. It should be noted that a number of mental health screening tools are available for physicians to use in such situations.

Figure 2. End-of-Life Option Act Has Stronger Protections Than Two Current Maryland Laws Impacting End of Life

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Voluntarily Stopping Eating and Drinking — VSED (as of 1993)</th>
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<td>No</td>
</tr>
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<td>Yes</td>
</tr>
<tr>
<td>Physician to Obtain Mental Health Evaluation if Concern about Patient’s Capacity</td>
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<td>Yes</td>
</tr>
<tr>
<td>Interpreter, If Necessary, When Physician Meets Independently with Patient to Determine If There Is Correcion</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Figure 3. Maryland Physicians and the General Population Support Aid in Dying

<table>
<thead>
<tr>
<th>Individuals Surveyed (respondents)</th>
<th>Support</th>
<th>Oppose</th>
<th>Neutral, Other or Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MedChi Survey (June-July 2016)</td>
<td>54%</td>
<td>42%</td>
<td>4%</td>
</tr>
<tr>
<td>Maryland Physicians (n=455)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medscape National Survey Fall 2014</td>
<td>54%</td>
<td>34%</td>
<td>15%</td>
</tr>
<tr>
<td>&gt;17,000 physicians nationwide</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maryland Residents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Momentum Analysis - Maryland Poll - Feb 2016</td>
<td>65%</td>
<td>26%</td>
<td>9%</td>
</tr>
<tr>
<td>Maryland Voters (n=1,100)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washington Post - Univ of Maryland Poll - Oct 2015</td>
<td>60%</td>
<td>33%</td>
<td>7%</td>
</tr>
<tr>
<td>Maryland Adults (n=1,006)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goucher Poll - Feb 2015</td>
<td>60%</td>
<td>35%</td>
<td>5%</td>
</tr>
<tr>
<td>Maryland Residents (n=794)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Polls</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gallup Poll - May 2016</td>
<td>69%</td>
<td>27%</td>
<td>4%</td>
</tr>
<tr>
<td>Adults Nationwide (n=1,025)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 4. Age-Adjusted Suicide Rates, All Ages, Nationwide and for Oregon and Washington, 3-Year Moving Average, 1988-2014


Continued on page 18
No Violation of Profession Ethics or the Hippocratic Oath

As physicians, we often confront profound ethical questions: Start or stop chemotherapy in a cancer patient? Initiate or cease ventilator support after a devastating stroke? The questions raised in AID are of a similar nature.

Living 2,400 years ago, Hippocrates could not envision today’s medical practices. Yet the oath, still administered in contemporary iterations to new physicians, remains an ethical standard of our profession. Not all directives of the original oath have survived as relevant. Of those that have, the dictums to “help the sick according to my ability and judgment, but never with a view to injury and wrong-doing” and to “abstain from all intentional wrong-doing and harm” are the focus in AID debates. The fundamental question becomes whether they are broken by granting or by not granting patients’ informed requests to bring their lives to a peaceful end, at a time and amid surroundings of their choosing, through AID.

A modern interpretation of the oath might be: Do what is right for the patient.

A Call for Engaged Neutrality

Organized medicine, including the American Medical Association (AMA) and American College of Physicians, has generally opposed AID. However, the AMA House of Delegates recently referred AID for additional study. In September 2016, MedChi restored its “neutral” position from that of “opposed.”

It is recognized that physicians’ training does not include the topic of AID or the use of pharmacologic agents for the purpose of ending life. Thus, there is a call for “engaged neutrality,” whereby professional groups allow for diverse views and for the development of support materials for participating physicians in states in which AID is practiced. Organizations in Oregon and elsewhere have developed clinical guidelines to ensure that AID practices prioritize quality of care and professionalism.

Conclusions

Hospice, palliative care, palliative sedation, medical marijuana, and alternative and holistic modalities provide relief for most, but not all, terminally ill patients who experience severe physical, emotional, or even existential pain. For the small minority who continue to suffer despite our best efforts, AID is another option.

We believe AID, a patient initiated and controlled means of pharmacologically accelerating imminent natural death, is a legitimate addition to the choices for those confronting a difficult death. Freeing patients, their loved ones, and physicians to discuss all concerns and options openly, and without fear of external judgment or the pall of criminality, is consistent with our responsibility to act compassionately. In deciding whether to assent to a request, physicians can take into account the patient’s physical, emotional, and spiritual status; the patient’s expressed wishes; unique circumstances; and the physician’s own moral convictions.

It serves no one—the patient, the medical community, or society at large—to deny patients the opportunity to consider this option and whether it is right for them.

References


For a complete list of references, please contact scarey@montgomerymedicine.org.
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Physician-assisted suicide is back on Maryland’s political agenda. The End-of-Life Option Act was introduced in the Senate (SB 418) and House of Delegates (HB 404) last winter. All thirteen of the Senate bill’s sponsors and all-but-one of the forty-one House sponsors are Democrats. The message from supporters is that in common with women’s rights, voting rights, gay marriage, and long-overdue raises to the minimum wage, it’s only a matter of time before physician-assisted suicide becomes legal. After all, it is the right thing to do. Right?

I’m a life-long Democrat who supports all those other liberal causes, but I oppose physician-assisted suicide, and I’d ask my fellow progressives to shine a cold hard light on this particular issue. Left-leaning voters have been the target of a decades-long branding campaign that paints hastening death as an extension of our personal freedoms. We should bring the same healthy skepticism to physician-assisted suicide that we do to claims of the safety of fracking, clean coal, and genetically modified food.

Groups such as Compassion and Choices, the organization spearheading SB 418 and HB 404 and similar bills elsewhere, skillfully use marketing techniques that characterize political propaganda: Redefine words to mean what you want them to mean. Repeat key points until they acquire an unquestioned air of truth.

“Suicide” is distasteful, so they promote “physician aid in dying,” “death with dignity,” and the “right to die.” And yet all of these mean taking action to end one’s own life, the dictionary definition of suicide. The media have largely adopted the assisted suicide movement’s terminology, so these euphemisms are worth unpacking here.

“Physician aid in dying” makes it sound like giving someone a lethal drug is an extension of hospice and palliative care. It is not. Palliative care physicians, such as myself, regularly aid people in dying by treating their symptoms and supporting them through the difficult practical and emotional tasks of completing their lives. In more than thirty-five years of practice I have never once had to kill a patient to alleviate the person's suffering. When other measures fail, palliative sedation for alleviation of physical suffering is reliably effective.¹ Alleviating suffering is different than alleviating the sufferer.²

“Death with dignity” implies that frail or physically dependent people aren’t already dignified. But they are. The United Nations (UN) Universal Declaration of Human Rights stipulates that all members of the human community are inherently dignified. People who are disabled, frail, or facing life’s end can be cared for in ways that allow them to feel respected, worthy, and valued.

The phrase “right to die” is brilliant branding. You will not, however, find a right to physician-assisted suicide or euthanasia within the UN Declaration of Human Rights, the Magna Carta, or the U.S. Constitution.³

Supporters of bills like SB 418 and HB 404 repeatedly assert that legalizing physician-assisted suicide is not a slippery slope. Evidence, however, shows that reasons for dispensing life-ending drugs are changing.

In the 1990s proponents in Oregon campaigned to legalize physician-assisted suicide in cases of unrelievable physical suffering. Oregon Health Authority research, however, shows that more than 70 percent of terminally ill patients who took doctor-prescribed drugs to end their lives didn’t cite physical pain as a concern.

The more-common issues were emotional or existential: loss of autonomy, inability to do things they enjoy, loss of dignity, and feeling a burden to family and friends.³

One need only look at Belgium and the Netherlands to glimpse the future. In both countries, suicide by self-administration of life-ending drugs and euthanasia by doctor-administered lethal injections have been available for several decades and are increasingly prevalent. According to the annual report from the Dutch Euthanasia Review Committees, 3.9 percent of all deaths in the Netherlands were intentionally hastened, including 5,277 people who were euthanized by physicians.⁴ Dutch people are being euthanized at their request by their public health system for non-terminal conditions, which include chronic pain, tinnitus, or blindness. In excess of fifty of those euthanized in 2015 suffered from psychiatric disorders. Many mentally ill patients who request euthanasia suffer from personality disorders and social isolation; depression, anxiety, and post-traumatic stress disorders are common.⁵

Think it couldn’t happen in the United States? Final Exit Network, one of the other key groups supporting HB 404 and SB 418, has its mission to...
advance: "...the basic human right of competent adults to choose to end their lives on their own terms when they suffer from irreversible physical illness, intractable pain, or a constellation of chronic, progressive physical disabilities."

The movement is also pushing to expand the means of hastening death to lethal injections delivered by physicians. Marcia Angell, MD, who regularly testifies in court cases and legislative hearings, wrote in favor of that in the New York Review of Books, "...after my husband’s death, I have come to favor euthanasia as well, for home hospice patients in the final, agonal stage of dying, who can no longer ingest medication orally." This is the practice in the Netherlands and Belgium that the American assisted-suicide groups still claim won’t happen here.

I share the sense of anger, urgency, and frustration over the sorry state of end-of-life care. There is a legitimate fear of dying badly that fuels this movement. The Institute of Medicine’s 2014 report, Dying in America,7 detailed deficiencies in medical training and practice that contribute to needless suffering. It also lays out steps that health care and long-term care systems, insurers, medical schools, and policymakers can take to reliably resolve this crisis. SB 418 and HB 404 address none of those; the bills merely give doctors legal authority to prescribe medications that patients self-administer to end their lives.

The authors and supporters of SB 418 and HB 404 have good intentions. However, I believe that deliberately ending the lives of ill people represents a socially erosive response to basic human needs. If people on both sides of this issue can remain civil and acknowledge the good intentions of those with whom we disagree, we can continue vigorously debating physician-assisted suicide while also being constructive and working to substantially improve care and the lives of people who are dying.

Progressive voters who support physician-assisted suicide should at the very least demand two important amendments to SB 418 and HB 404. First, medical schools must increase required curriculum in palliative care (to be at a minimum on par with the hours devoted to obstetrics and neonatology) and test medical students’ performance on managing pain and conducting conversations about serious illness before giving them a degree. Second, the Maryland Board of Physicians must institute tests of basic skills of pain management, communication, and shared decision-making before licensing a physician. Of course, while opposing SB 418 and HB 404, conservative voters should advocate for these measures as well.

Sponsors and supporters will worry about encumbering their bills. Many of us worry about the effects of their social engineering. If the legislature decides to grant doctors authority to write lethal prescriptions, how could lawmakers do any less?

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References

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

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

Achieving a Sense of Purpose and Hope

I realize the reader may think it somewhat paradoxical that a person with a terminal illness—defined as a life expectancy of six to twelve months—may still achieve a sense of purpose and hope in his or her remaining time. Surprisingly, this often is the case, particularly when the physician introduces—and the patient embraces—the notion of palliative care in which efforts are directed at the patient’s physical, emotional, social, and spiritual comfort rather than a cure. In truth, good palliative care should accompany curative efforts from the time of diagnosis and become the main focus whenever the patient so chooses, or when the disease becomes incurable.

After many years of practice, I have observed that physicians often are reluctant to “let go” of efforts to cure lest they dash the hopes of patients who persist in demanding aggressive interventions beyond a point when there is a realistic chance of substantive gain. Physicians also may provide such treatment in an effort to be kind, to encourage patients’ hopes, and because they are uncertain how to help patients transition from seeking cure to seeking comfort. Aggressive treatment at this late stage of illness invites disappointment, because the hopes it raises are false ones. Late stage treatment often leads to prolonged hospital stays involving care that is simply not beneficial. I believe physicians have a moral responsibility to help such patients make the transition toward the achievable goal of maximizing quality of life while there is still the time and energy to enjoy it.

Transitioning the Focus of Care from Curative to Comfort

The transition from curative-based care to a focus on palliation and comfort can be accomplished in a number of ways. The physician can say to the patient, “While it has become sadly clear that your disease cannot be cured, we can still do much to maximize your comfort and assure that you have the greatest quality of life in whatever time is remaining for you…” It does not serve the patient to say, “There is no hope, and there is nothing more that I can do for you…” Rather, in this difficult situation, one can state positively to patients, “There is much that we can hope for and work toward.” This may sound paradoxical, but should become clear when one explores some of the multiple dimensions of hope.
Hope for cure is not the only thing that we can offer patients. However, it is clear that many physicians feel that way, accounting for some of the depression that patients and their physicians feel when a disease reaches its terminal stage. The different shapes of hope may constitute various goals that can guide treatment. Certainly, patients' hopes for physical comfort can be addressed with control of some of the most prevalent symptoms of terminal diseases such as pain, fatigue, anorexia, constipation, edema, skin ulcers, insomnia, nausea, and dyspnea. These symptoms are controllable almost all of the time using reversible illness with low-burden interventions.

Case Two: CK — Treating Reversible Problems with Low-Burden Interventions

An eighty-one-year-old retired physician with recurrent gastric cancer was referred to hospice ten months previously when he started to decline and lose weight. He and his family enjoyed the support of the hospice team, all of whom visited him regularly at home. Though he denied pain, he was prone to recurrent fevers, thought to be cholangitis from a blocked biliary drain. He was treated with antibiotics and replacement of his biliary drain. His goal was to take a cruise with his family to Alaska before he died. As his weight continued to decrease, he experienced hypotension with orthostatic change, unresponsive to periodic infusions of normal saline. He became too weak to walk on his own, and the initial impression was that his disease was accelerating toward his death. However, given that his cancer had metastasized to his adrenal gland, an empiric trial of dexamethasone and Florinef was begun. He improved dramatically in both strength and well-being. His hypotension and orthostasis vanished. He was able to take his cruise. The case illustrates how an able hospice team can enhance the life that is left by treating potentially reversible illness with low-burden interventions.

Physicians must assess the patients' current quality of life and recommend a treatment plan to best honor these hopes and goals. Physicians will be doing them a tremendous service by providing them with maximal comfort as they approach the end of their lives. This is in keeping with the notion of a “Good Death” in which patients

- achieve total physical comfort,
- are treated with respect and dignity,
- are never abandoned by their physicians,
- achieve closure in both personal and community affairs,
- maintain a sense of continuity of self as a unique person until death, and even
- achieve some reconciliation and renewed intimacy with those they love.

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

Physicians also must believe that when cure is not possible, there is actually much to hope for and even to accomplish. Physicians can help patients pursue a different and very rewarding type of hope. Good palliative care, whether given by one’s primary care physician, consultation in the home, or through a comprehensive hospice program, will increase the chance that a patient can stay at home. Palliative care is consistent with current health care goals: to shift care to the home and avoid hospitalization whenever possible.

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I Am Ready to Die, So What Options Do I Have?

Exploring Palliative Sedation and Voluntarily Stopping Eating and Drinking as Last Resort Options

Case Study
A sixty-year-old man with metastatic breast cancer, with multiple bone and liver metastases refractory to treatment, was referred for a palliative care consultation. His symptoms were well managed, and he accepted that there were no other effective treatment options for his cancer. He was referred to hospice, but he also wanted the option of physician aid in dying (AID) if his suffering became unacceptable. He thought it was absurd that others should determine his end-of-life options. He was receiving state-of-the-science palliative care. He was carefully assessed and found to have decision-making capacity. Living in a state where AID is legally prohibited (New York), he was presented with the possibility of two other “last resort” options should he need them in the future.

Palliative Sedation
Palliative sedation (PS), an intervention available to patients at the end of life who are experiencing extreme suffering and are not responding to standard palliative treatment, has been legal in Maryland since 1999. PS is defined as deliberately decreasing a patient’s level of consciousness with the intention of relieving refractory, severe symptoms that otherwise cannot be addressed despite other intensive palliative efforts. A decreased level of consciousness is generally achieved by “primary sedation,” giving medications specifically designed to reduce consciousness as a means of escaping suffering, but can also occur via “secondary sedation” as an unintended side-effect of symptom-targeted therapy. An example of primary sedation is administering a barbiturate or benzodiazepine to a patient with refractory agitated delirium with the primary endpoint of reducing the patient’s consciousness to the point at which the agitation is relieved. The physician tries to preserve conscious awareness as much as possible, though sometimes sedation to unconsciousness is clinically required to relieve the symptom. An example of secondary sedation is administering a proportionate amount of opiates to a patient with refractory dyspnea with the potential side effect of sedation. In this case, adequate relief of dyspnea will be the primary end point, minimizing the amount of the side effect of sedation if possible to achieve that end.

Primary PS is generally considered when death is already imminent from the patient’s underlying disease, and administered continuously until the time of death once initiated. PS can also be administered intermittently with periods of decreased sedation to see if heavier sedation is still needed in more uncertain prognostic circumstances. One of the prerequisites for continuous PS, which results in loss of conscious awareness, is that the patient’s death is expected to occur within a few weeks at most, although the concept of “respite sedation” exists, which can be administered outside the context of imminent death, potentially associated with concomitant ventilatory support and artificial food and fluids. While PS may hasten the dying process directly (causing respiratory depression, preventing physiologic compensatory mechanisms) or indirectly (dehydration, starvation), the clinician’s primary intention of this treatment is generally NOT to shorten life but rather to relieve intractable symptoms and decrease suffering.

PS is most commonly used for refractory symptoms such as pain, dyspnea, and delirium, or a combination of symptoms. The working definition of “refractory” has been that existing palliative interventions cannot provide relief in an acceptable period of time. The clearest indication for PS would be to treat otherwise refractory physical suffering, but the specifics may vary for each patient and family depending on their concepts of suffering, dignity, and symptom relief.

While the notion of beneficence in relieving refractory suffering through PS rings true to the ethos of Palliative Care medicine, PS is still occasionally controversial. Despite development of various guidelines for how, when, and on whom PS should be performed, significant variation and inconsistency exists in practice. The more there is an anchor of significant, intractable physical suffering, the more there is ethical agreement about the permissibility of PS. The more that a patient’s suffering is predominantly emotional, spiritual, or existential, the less there is such a consensus. Of course most patients do not have the luxury of cleanly separating physical from psychosocial suffering, so concerns about the ethics of sedation in the presence of severe psychological distress have cloaked the subject with considerable controversy.

Finally, there are some similarities between PS and AID (aid in dying) because of active physician involvement in a procedure that may directly shorten a patient’s life. When the patient’s intention is purely to escape intolerable suffering and not to hasten death, then the doctrine of double effect and the balance between intended effects and foreseen but unintended consequences comes into play. Similarly, the physician’s intention in all cases of PS should be primarily to relieve otherwise intolerable suffering with the foreseen yet unintended effect of shortening a life, thereby making the practice morally and legally justifiable. If the patient’s intention is more complex (he or she would have preferred a medically hastened death if legally available, but is accepting PS as the next best option), then such an uncomplicated justification is generally not viable.

For our patient, PS would not have been an immediate option given the fact that his physical symptoms were controlled with standard palliative care interventions. If, however, at some point during
the course of his illness and ultimate decline he developed intractable physical symptoms, this option could certainly be revisited, although his concomitant desire for a hastened death might have made it difficult to make a decision.

**Voluntarily Stopping Eating and Drinking**

A second option that can be considered in cases of unacceptable suffering at end of life is voluntary stopping eating and drinking (VSED), which has been legal in Maryland since 1993. VSED is an action of a decisionally capable person who has appetite and thirst, and the physical ability to eat and drink, but who overrides that desire and decides to completely stop eating and drinking with the primary intention to hasten death and escape unacceptable suffering.\(^8\)

The main argument in favor of supporting VSED is based on the principle of autonomy. A patient with decision-making capacity who is terminally ill has the legal right to decline life-sustaining measures, including forms of artificial nutrition. Choosing to stop eating and drinking can similarly be considered a waiver of life-sustaining measures to not further prolong suffering. It differs from forgoing medical treatment (such as artificial hydration and nutrition) because it involves a conscious choice to stop taking ordinary food and liquids despite being physically able to partake.

Although VSED may align with a natural progression for patients at the end of life who lose interest in eating and drinking, patients initiating VSED still have hunger and thirst that must be compensated for. Considerable patient conviction and discipline is required to carry out VSED to completion. The physician still needs to play a role in assessing the patient’s capacity to make such a major decision, and then managing the dying process and palliate symptoms, such as dryness, thirst, and delirium. However, unlike PS and PAD, VSED remains primarily directed and controlled by patients and not by physicians.\(^9\) It is important to note that these patients always have the right to change their mind and resume eating and drinking at any time.

The main argument against VSED centers on nonmaleficence, to do no harm. VSED attempts to alleviate untreatable suffering by hastening death. Participating in the process may be viewed by some health care providers as harming patients by assisting in their deaths. There is also debate about whether it is permissible to tell all terminally ill patients about this “last resort” option, or only those patients who ask about options for hastening death. The worry is that presenting this as an “option” will be perceived to be encouraging patients to take this route, resulting in “physician stimulated self-starvation.”\(^9\)

On the other hand, informing a patient with decision-making capacity of options, with the risks and benefits included, is an integral part of the medical process, and patients have a right to know the full range of choices available to them. Just as with other medical decisions, only the patient can understand his or her own experience and suffering, and make the best decision.

In comparison with other options such as PS or AID, VSED requires a longer period to carry out and is therefore not appropriate for patients with severe, immediate physical suffering. Depending on the patient’s underlying condition(s), the dying process from VSED usually takes ten to fourteen days, if the patient is vigilant about not drinking (it can last indefinitely if sips of liquids are regularly taken).\(^10\)

There also can be moral distress experienced by care providers and family members about their role in intentionally hastening death. Food and drink can have a profound social and cultural significance, viewed as an expression of love and support, so not readily providing or encouraging food can be experienced as denying basic comfort, sustenance, and care. VSED should be considered as a last resort option only for patients with full decision-making capacity who request VSED when conventional palliative measures have not alleviated significant suffering.

Although our patient appreciated being offered the possibility of PS and VSED, he remained angry that the option he strongly preferred, AID, was unavailable. He stayed in hospice for more than six additional months when he developed multiple pathological bone fractures. He could not get out of bed and was in pain with any movement. He was admitted to our palliative care unit to manage his pain and receive nursing support. He was psychologically ready for his death, and did not want this condition prolonged in any way. He again requested AID, which we could not provide in our state where it is legally prohibited. The last resort option that best fit his circumstance was VSED, along with excellent symptom management. The only major symptom he had was dry mouth, which was managed by giving him small amounts of liquid that he swished in his mouth and spit out rather than swallow. He gradually became less responsive, but was not at all agitated. He vigilantly adhered to the plan, and died ten days later with his family at his bedside. It was clearly not the death he would have preferred, but he appreciated our willingness to help him find an escape from his suffering that was under his control.

> "The main argument in favor of supporting VSED is based on the principle of autonomy. A patient with decision-making capacity who is terminally ill has the legal right to decline life-sustaining measures, including forms of artificial nutrition."

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**References**


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Decision-Making Capacity: What is It? Who Determines Capacity?

Your patient is an eighty-seven year-old man with mild dementia admitted with pneumonia. He is having respiratory failure, but appears mentally appropriate and states he doesn’t want life support. However, the family states he’s demented and incompetent, and therefore demands intubation. How do you proceed?

Patients have the right to make their own decisions, even bad decisions, if they have medical decision-making capacity. Autonomy, the patient’s right to make an informed choice to receive or refuse medical treatments, is at the core of all medical decision making in America. However, how we determine which patients are able to make such decisions, and who is responsible for making the distinction, is often confusing.

Scope of the Problem

The aging of the U.S. population is well documented, as is the association between age and cognitive dysfunction. There is also a strong correlation between cognitive impairment and lack of capacity. In a healthy outpatient population, there may be fewer than 3 percent of individuals who lack capacity. However, as this rate increases to 26 percent for hospitalized patients, and 44 percent for those who live in a long-term facility, so does the frequency with which most practitioners face the question of capacity.

As patients are assumed to have capacity until proven otherwise, the onus is on the provider to prove a lack of capacity. Unfortunately, providers only recognize lack of capacity 42 percent of the time, meaning they allow many patients who truly aren’t capable of making an informed decision to make one anyway. For providers, there is a “Bias of Agreement” – a term we coined—which means that providers are most likely to question capacity when patients do not agree with the recommended plan of care. Conversely, pleasantly demented individuals who readily agree to all recommendations will rarely have their capacity questioned.

Capacity versus Competency

The terms capacity and competency are often used interchangeably when speaking of a person’s ability to make an informed decision for his or her own health care. The American Bar Association and Commission on Law and Aging consider these terms to be interchangeable. However, many state laws make distinctions, and the medical literature supports using the terms in different ways. Traditionally in the medical field, medical decision-making capacity—which we’ll refer to as capacity in this article—is a clinical judgment made by a medical provider.

Capacity is fluid and can frequently change because of both physical and emotional conditions. For example, a patient with a urinary tract infection and delirium may easily lack capacity in the ER, but have full decision-making capacity after twenty-four hours of antibiotics. It’s also possible for a patient to retain capacity to make a simple decision while lacking the insight to understand or process a more complex medical issue.

Competency is a legal judgment that is decided by the courts and is typically a global assessment indicating the patient lacks the ability to make any of his or her own decisions, from health care to finances to legal matters. If incompetence is determined, a guardian is appointed who becomes the medical decision maker unless reversed by the courts later.

Assessment of Medical Decision-Making Capacity

Patients are believed to have capacity if they meet five key criteria: A patient must
1. understand his or her medical problems and current clinical condition.
2. understand the consequences of treatment options, including no treatment.
3. judge the relationship between options, consequences, and personal goals for treatments.
4. reason and deliberate about options.
5. communicate decisions in a meaningful manner.

While such a list may look straightforward, there are many potential barriers that make it difficult to determine capacity in some cases. Common examples including hearing loss, language barriers, and cultural differences in how patients talk about health care issues. Additional barriers are provider education on methods used to determine capacity, and time constraints.

Situations involving underlying psychosis or psychiatric illness require careful consideration or even further consultation. For instance, individuals who are actively hallucinating, with the delusion the devil will steal their soul if they go through surgery, might on the surface meet the five criteria listed above. However, such individuals lack capacity to make their own decisions. Patients with significant depression who refuse medical care present a less obvious case than active psychosis. If it is determined that depression is affecting a patient’s decision making, they may not be capable of making a truly rational decision. For patients requesting a prescription for life-ending medication in states where it is legal (see Strauss & Hill article, page 16), guidelines suggest physicians can screen for depression with a validated instrument, such as the Patient Health Questionnaire (PHQ-9), or other possible instruments. That said, it is not likely that well-controlled psychiatric disorders affect a person’s ability to consider and make an informed decision.
Who Can Decide Medical Decision-Making Capacity?

A provider who speaks with a patient and then proceeds with treatment has made the decision that the patient has medical decision-making capacity. Or, as capacity is assumed, any time a provider sees a patient and then asks the patient’s proxy to make a decision, the provider has determined the patient lacks capacity. For many providers, this is a decision that is made multiple times each day. While neuropsychologists are the true experts and should be called in more complex cases, a physician can legally make this determination in every state. In some states, including Maryland, an advanced practice clinician, such as nurse practitioner or physician assistant, also may make this determination.

Tools Used to Determine Decision-Making Capacity

There are a variety of tools that may be used to measure cognitive impairment and assist in determining capacity. The Mini-Mental State Examination (MMSE) and the Aid to Capacity Evaluation (ACE) are two valid and easy-to-use instruments for assessing decision-making capacity.

The MMSE includes a thirty-point questionnaire that measures cognition, not true capacity. However, scores of twenty-five or higher are associated with presence of capacity, while scores of less than twenty suggest a patient likely doesn’t have the cognitive ability to make an informed decision. The advantage of the MMSE is that it is easy to administer, does not require any specific training, and is familiar to most providers. The main disadvantage is that if the score is between twenty and twenty-four, it does not help in making a determination.

The ACE is a decisional aide that was developed specifically to help providers assess capacity. It involves a semi-structured interview with a patient in which seven areas are addressed. These areas include the person’s ability to understand the medical problem, the proposed treatment, treatment alternatives, the option to refuse treatment, the consequences of accepting treatments, and the consequences of refusing treatment. The ACE also assesses whether the person has the ability to make a decision unaffected by depression or psychosis. The ACE takes about ten minutes to complete, and includes specific guidelines for administration and scoring. While the ACE is likely not familiar to many providers, it can be quite valuable and is worth the time spent learning how to administer.

Summary

Many providers face decisions about capacity every day. To evaluate capacity efficiently, it is important to know the five criteria and how to question patients to establish each point. It is more important to assess a patient’s rationality than to evaluate whether he or she makes a “good decision.” Be aware of the instruments available to assess capacity, including the MMSE and the ACE tools. Finally, when capacity is in question, careful documentation that supports a determination is necessary, and providers should be prepared to make a referral to neuropsychology for a more detailed evaluation and recommendations.

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Planning for the End of Life

Dan Morhaim, MD

We often approach issues in public health by dividing the population into cohorts. However, there is one cohort to which we all belong: we are all going to die.

Here's a useful exercise. For the next fifteen seconds, please consider the following. Where do you want to be when death comes? Who is with you? How do you want to be treated?

When I pose these questions to audiences, the answers are consistent: at home, with family and close friends, pain free, and comfortable. Nobody says killed in a car crash, shot by a terrorist, or dying in an ICU long past any hope of recovery, connected to tubes and machines, with family and friends down the hall.

Unlike our ancestors, more than 80 percent of us will die from a more or less chronic disease. We are the first generation in human history that is likely to have some say about how, when, and where we die. We can take advantage of the best treatment that modern medical science has to offer. At the same time, if we choose to forego further treatment because it is not needed or helpful, we have the recognized legal right to do so. We are empowered in an unprecedented way, a way that necessitates new considerations.

How can we plan for the end of life?

Advance Directives

The first step in planning for the end of life is to increase the rate of completion of advance directives, something currently done by about 35 percent of the adult population overall, with much lower rates in minority communities. Advance directives (AD) forms are legal, free (or very low cost), easily completed, and readily available from many sources.

As long as a person is competent, the advance directive is not needed. But what happens when the patient becomes unable to guide medical decisions? The advance directive states how much care one wants to receive and designates a surrogate to make medical decisions when necessary.

Advance directives do not limit care. Rather they help guide care according to an individual’s needs and values. Depending on age, clinical condition, and beliefs, some people may choose to have all the care possible and some to limit it greatly. 

“Advance directives do not limit care. Rather they help guide care according to an individual’s needs and values. Depending on age, clinical condition, and beliefs, some people may choose to have all the care possible and some to limit it greatly.”

Physicians and other providers have an important role to play. Considering that only 12 percent of respondents in our study with an AD had obtained information from their physicians, it can be that physicians and their patients are not having these discussions, or at least not to the extent they should be. Clinicians’ reluctance to discuss these matters has been identified as a barrier for advance care planning in the outpatient setting. Yet, more than 61 percent of the adults in our sample said they had preferences for end-of-life care, and most wanted to discuss these issues with their physicians. Lawyers, clergy, therapists, or trusted family advisors have a role to play. An overwhelming number of people want to talk with their primary care physicians.

I’ve seen these issues play out as a career emergency medicine physician. Too often, I’ve seen patients long past any hope of meaningful recovery subjected to the full court press of modern medical care: CPR, ventilators, chemotherapy, extensive surgical procedures. It was my personal experience with the death of my stepfather Max that opened my eyes to other end-of-life possibilities.

Modern medicine, surgery, and dialysis gave Max at least ten extra good years of life. But there came a point when it became apparent to him and to our family that the end was approaching as he deteriorated physically and mentally. Finally, he decided to forego dialysis, knowing full well what that meant. At first, friends and family came to visit, and we shared stories, laughter, tears. In the last few days, only my mother and I took care of him until he quietly died at home in bed. This was in marked contrast to the high-tech deaths I had witnessed at work as a health professional. And it was the only time I have been present, outside of work, when someone died. Max’s passing provided me with a meaningful family and spiritual experience I wouldn’t otherwise have had.

MOLST, Hospice, Palliative Care

There are many services now available to support patients and families as they confront the inevitable. MOLST (Medical Orders for Life-Sustaining Treatment) forms are required in Maryland (and almost every other state) for specified high-risk patients so that physicians and other designated providers can outline detailed treatment plans already agreed to by patients and family members.
Palliative care, increasingly common for anyone with a serious, progressive illness, provides a range of services including an explanation of the illness and what to expect, a focus on symptom management, and a clarification of care goals—all with a view toward enhancing the patient’s quality of life. Hospice care, which provides all of the above to patients who have a terminal illness, is coordinated by an interdisciplinary team and is the most comprehensive package of palliative care in this country. All patients deserve excellent palliative care regardless of the stage of their illness. One *New England Journal of Medicine* study demonstrated that “[a]mong patients with metastatic non–small-cell lung cancer, early palliative care led to significant improvements in both quality of life and mood. As compared with patients receiving standard care, patients receiving early palliative care had less aggressive care at the end of life but longer survival.”

In other words, the patients lived longer, spent less money, and were happier. That’s an outcome we should all want.

### Health Care Costs at the End of Life

Any discussion about health care policy must include the topic of health care finances. According to the Dartmouth Institute for Health Policy and Clinical Practice, a about one-third of Medicare’s nearly $700 billion annual budget is spent on patients in the last six months of life. That means that about $231 billion each year. This expense will only increase as the baby boom generation lives longer and as technology becomes more available and expensive.

Advance directives are not just for old people. The three most famous legal cases in the United States involved women under thirty years of age: Nancy Cruzan, Karen Quinlan, and Terri Schiavo. Completing AD forms may be even more important for young adults, who tend to get into trouble unexpectedly and catastrophically, whereas older people receive a diagnosis that allows them some time to process their thoughts.

We attempt to control health care costs in a variety of heavy-handed ways: increased premiums; bureaucratic red tape; costs passed on to businesses, individuals, and taxpayers; higher co-pays and increased deductibles; lower reimbursement rates to providers (the ones actually delivering health care); and services directed by “bean-counters” instead of by health professionals. Imagine if completing an advance directive and using the other end-of-life options using an AD instead of one-third or fewer. Let’s assume a 10 percent savings in health care costs because more people would choose to forego expensive hospital care in favor of more humane, but less costly, home care. Even with such a conservative estimate, $23 billion dollars would be saved for Medicare alone. Imagine further the impact on Medicaid and commercial insurance. In effect, we’d be saving money the right way: by empowering individuals and respecting their choices.

Can this be done? It happened in La Crosse, Wisconsin, where having conversations about end-of-life care became a routine activity thanks to the active involvement of the health care, business, and faith-based communities. As a result, “It turns out that if you allow patients to choose and direct their care, then often they choose a course that is much less expensive,” says Jeff Thompson, CEO of Gundersen Health System. In fact, La Crosse, Wisconsin, spends less on health care for patients at the end of life than any other place in the country, according to the Dartmouth Health Atlas.

Maryland is a high cost-of-death state. A study done by the Department of Health and Mental Hygiene (DHMH) showed that “Maryland is just behind the District of Columbia in having the highest inpatient Medicare costs in the last six months of life. Average costs in Maryland are $24,818, which is more than $8,000 more than the national average and $14,000 more than the Idaho, the state with the lowest average cost.”

### Actions in Maryland: Now and in the Future

We’ve taken important steps here. In 2016 legislation was enacted that makes an electronic advance directive registry possible, and we joined many other states and organizations in recognizing April 16 as National Health Care Decisions Day. But we still have a long way to go until completion of advance directives and MOLST become as routine in the health care system as taking vital signs. No matter how we view it, despite the outstanding medical care available in the United States, our death rate remains the same as that of the poorest nation on earth: one per person.

There are many resources available to help you and your patients break down the barriers so you can have this critically important discussion. My book *The Better End* is one example. In his book review in the *Baltimore Sun*, Jay Hancock offered the following: “Humans are the only creatures that can contemplate their own demise. They might as well get ready for it. The best way to avoid an unwanted death panel is to set up your own.” Additional resources are available online.

As physicians, nurses, social workers, EMTs, physician assistants, pharmacists, and anyone involved in the delivery of care, it’s our responsibility to treat people well, both in life and when the end of life comes. We are in the unique and unprecedented position of being the first generation in human history to have some say about how we die. We should look at that as a positive opportunity and then take advantage of it.

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The Primary Care Track: A University of Maryland School of Medicine’s Initiative to Improve Health Care Disparities in Maryland

Richard Colgan, MD, Linda Lewin, MD, Nikkita Southall, MD, Mozella Williams, MD, and Barbara Perez Marquez, MFA

Introduction and Existing Disparities

Today, more than 50 million people in America lack access to health care, of which 463,000 are in Maryland. Our country needs more primary care physicians and advanced level practitioners, particularly in underserved rural and urban communities. According to Barbara Starfield, MD, famed pediatrician, researcher, and primary care advocate: “by every accepted epidemiological measure including: birth weight, infant mortality, life expectancy, primary care-oriented health systems are associated with healthier populations that live longer. Increasing the number of primary care physicians is positively associated with improved health outcomes. But increasing the number of specialists appears to have the opposite effect... A 20% increase in the number of primary care physicians is associated with a 5% decrease in mortality.”

Much like other parts of the country, Maryland struggles to recruit and retain health care workers in rural areas. On the Eastern Shore, all nine counties are listed wholly or in part as Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs). All three of the counties of Southern Maryland also meet the criteria for MUA designation.

In addition, Maryland is facing both physician and other health-professional workforce shortages. A comprehensive 2008 study conducted by the Maryland Hospital Association (MHA) and Med Chi, 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 shortages occur in rural parts of the state and will worsen, 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 three regions fall significantly below national levels for currently practicing physicians. Southern Maryland at present has critical shortages in twenty-five of thirty physician categories (83.3 percent); Western Maryland twenty of thirty (66.7 percent) and the Eastern Shore eighteen of thirty (60 percent).

All of Maryland’s twenty-four county jurisdictions, with the exception of Baltimore City and Anne Arundel, Baltimore, Howard, Montgomery, and Prince George’s counties, meet Maryland State designation as rural, and ten rural counties have partial or full designations as primary health care professional shortage areas. These ten counties are located in the Western or Eastern parts of the state. According to the most recent report of the Maryland Health Regulatory Commission, Maryland’s rural communities differ greatly from the urban counties; specifically, they have fewer health care providers, higher rates of chronic disease and mortality, significant disparity of socioeconomic characteristics, and low levels of health literacy.

In Maryland, there are also significant disparities in patient outcomes in the areas of diabetes, hypertension, and HIV/AIDS, among others. The Maryland Department of Health and Mental Hygiene reported that the death rates for African American citizens exceed those for white citizens in all twenty-two jurisdictions that had data available, and that ten of the top fifteen causes of death occur more commonly in African Americans than in whites.

Bridging the Gap

A recent study showed that Maryland ranks fiftieth in the country when it comes to the number of graduating fourth-year medical students who choose careers in primary care. Efforts to increase the number of medical school graduates who go on to practice as generalists and join the primary care workforce in underserved communities are critical in increasing access to care and reducing the health disparities that exist in our rural Maryland communities. Academic–community partnerships, such as the University of Maryland School of Medicine (UMSOM) Primary Care Track, are models for addressing these needs.

The Primary Care Track (PCT) is a collaborative five-year HRSA-funded curricular...
offering that seeks to address some of the challenges noted above. This longitudinal elective program, which welcomed its first class in August of 2012, introduces students to primary care role models in underserved communities early in medical school training. PCT’s goal is to increase the number of University of Maryland medical students who choose primary care careers and who return to practice in the underserved communities where they were trained. The PCT accepted its newest participants, sixty-four students from the Class of 2019, the programs largest class to date, in the fall of 2015.

A recent article in the Washington Post cited the UMSOM’s PCT, highlighting how some medical schools are looking to address the need for more primary care physicians in underserved areas. Academic Community Outreach is an important goal of the University of Maryland School of Medicine’s Dean, Dr. E. Albert Reece. At this year’s annual Association of American Medical Colleges annual meeting, the University of Maryland School of Medicine was recognized as a finalist for the Spencer Foreman Award for Outstanding Community Service for its outreach efforts. The PCT looks to build on these successes by creating stronger partnerships within our statewide community. In addition to being a leader in breaking medical research and scholarly activities, the School recognizes that its responsibilities include the disease prevention and health care needs of the citizens of the state of Maryland.

To date, a total of 193 students in years 1 and 2 have chosen to enroll in the PCT, allowing them to learn about primary care beginning in their first year of medical school. PCT students participate in monthly Grand Rounds addressing issues relating to Primary Care. The table below includes examples:

<table>
<thead>
<tr>
<th>Primary Care Track Topics:</th>
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<tbody>
<tr>
<td>Pillars of Primary Care Medicine</td>
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<tr>
<td>The Role of the Primary Care Physician in Public Health</td>
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<tr>
<td>Smoking Cessation</td>
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<tr>
<td>Screening &amp; Prevention</td>
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<tr>
<td>A Search for Empathy</td>
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<tr>
<td>The Affordable Care Act</td>
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<tr>
<td>Disparity &amp; Poverty</td>
</tr>
<tr>
<td>Promise Heights: Making a Difference in a West Baltimore Neighborhood</td>
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<tr>
<td>Asthma in Children</td>
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<tr>
<td>Primary Care in Underserved Populations</td>
</tr>
<tr>
<td>Primary Care for the Indigent</td>
</tr>
</tbody>
</table>

Students in years 1 and 2 spend one half-day per month with one of fifty on-campus or sixty-one off-campus faculty members. By shadowing a family medicine physician, general internist, or general pediatrician, PCT students have the opportunity to learn first-hand how to care for the underserved from primary care doctors throughout Maryland who serve as role models in partnership with one of the three regional Maryland Area Health Education Centers (MAHEC). The students are afforded an opportunity to work with these same preceptors during years three and four.

The mission of the MAHEC, located in the UMSOM’s Department of Family and Community Medicine, is to improve the health status of Marylanders through community educational partnerships that foster a commitment to enhancing health care access in the rural and urban underserved areas of the state. Regional Maryland Area Health Education centers, located in Cumberland, Cambridge, and Baltimore, Maryland, coordinate rotations for students in their first summer when each will work eighty hours alongside a physician in Western Maryland, on the Eastern Shore or in Baltimore City.

Making a Difference with Next Steps

A poll of the specialty choices of this year’s graduating fourth-year PCT students reveals that about 75 percent have chosen Family Medicine, Internal Medicine, or Pediatrics for their residency training. The PCT demonstrates that the UMSOM is as concerned for those whom we serve locally as we are those whose lives we impact globally by introducing interested medical students to primary care early in their training. PCT offers another model to increase the number of medical students choosing primary care. Likewise, an interprofessional effort would be a logical extension of this program (e.g. including the exposure of advanced level practitioners to work collaboratively in a similar model). The authors hope to develop such a program, the Underserved Care Track, to include physician assistant students, as a next step in addressing the challenges of an inadequate primary care work force.

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The Electron and the X-ray

Barton J. Gershen, MD
Editor Emeritus

DNA fragments are usually identified by the Southern Blot test. Restriction endonucleases are utilized to cut nucleoproteins into short segments. These segments are then separated by gel electrophoresis, and subsequently matched with RNA target probes. This technique was first described by, and named for, British biologist Edward M. Southern. A comparable assay, which is used to identify proteins, has been lampooned “the Western Blot” test by some droll scientists from California.

The term electrophoresis derives from the Greek word elektrón, which means “amber,” the fossilized brownish resin often found along seacoasts. Today the term electron refers to a negatively charged particle. This giant semantic leap in the connotation of “electron” stems from the fact that static electricity was originally discovered when amber was rubbed with a cloth. Thus, the electrical phenomenon shanghaied the native Athenian word, and forever altered its meaning.

The suffix of electrophoresis derives from the Greek pherein: “to carry.” Therefore, electrophoresis means “to carry a charge.” (Christopher is “one who carries Christ.” Semaphore is a “signal carrier”—from Greek sema: “sign.” The field of semantics derives from the same root.)

Colloids are large molecules in suspension. When they are subjected to an electrical current, these molecules move toward the anode or the cathode side of the instrument, depending upon the net electrical charge on the surface of each particle. Arne Tiselius (1902–1971) first described and utilized electrophoresis in separating, identifying, and quantifying proteins, for which he was awarded a Nobel Prize in 1948.

The term Collaid may be traced to the Greek word kola, “glue,” + oides, “the same as, or like.” Therefore, colloid means “glue-like,” and refers to a thick, sticky mixture of insoluble particles.

Collagen, the fibrous protein substance within connective tissue, comes from kola, “glue,” + genao, “to produce.” Collagen, therefore means “to produce glue,” and may be traced to the glutinous substance generated by boiling connective tissue, such as animal hides, a process perfected by Egyptians around 3,000 B.C.

The root word genao also occurs in oxygen and hydrogen. The Greek word oxus, “sharp,” was used by Antoine Lavoisier, the “father of modern chemistry,” who mistakenly believed that oxygen was a constituent of all acids (this is obviously true for hydrogen). Oxus—“sharp”—referred to the sour taste of all acids. (An oxymoron—such as “jumbo shrimp”—is a rhetorical expression containing contradictory terms. It is composed of Greek oxus, “sharp,” + moros, “dull” (as in moron)—that is, something both sharp and dull.) The term hydrogen is comprised of Greek hydor, “water,” + genao, “to produce,” that is, “a substance which generates water.”

Antoine Lavoisier, certainly one of the leading minds of his generation, was guillotined on May 8, 1794, during the “reign of terror,” following the French Revolution. Joseph Lagrange, the eminent French astronomer, said of his contemporary Lavoisier: “A moment was all that was necessary to strike off his head, and probably a hundred years will not be sufficient to produce another like it.”

A collage is created by gluing bits and pieces of artwork together. The term kolla may also be detected by examining ancient Greek manuscripts. They often contained a page which was glued to the frontpiece, and which listed the contents of the manuscript. This page was called a protokollon from proto, “early or first,” + kola—that is, “first glued.” Ultimately the English word protocol derives from this source. Colloid, collage, and protocol, therefore derive from a rather sticky common source.

In 1875, Sir William Crookes, an English physicist (1832–1919), began a series of experiments using a glass tube, from which he had removed most of the air. He called this a vacuum tube (Latin vacuo: “empty”). One of his investigations led to the development of an ingenious toy known as a radiometer. (Tiny metal vanes colored white on one side and black on the other, spin around inside a vacuum glass cylinder when they are exposed to a light source.)

In a more important experiment, Crookes enclosed a cathode electrode within his vacuum tube. As he heated the electrode filament of this cathode, he observed a steady emission of electron radiation. Vacuum tubes such as these are called “Crookes’ tubes.” They have led to the development of incandescent light bulbs, oscilloscopes, and television receivers.

On November 5, 1895, the chairman of the physics department at the University of Wurzburg, Germany, entered a darkened room, and began a series of experiments using a Crookes’ tube. He was particularly interested in luminescence, the induction of a glowing light from certain chemicals when they are struck by radiation from the cathode. On this particular day, the physicist had deliberately shielded his vacuum tube with black cardboard, in an attempt to block the transmission of electron radiation.

The cathode tube was turned on and a strange thing occurred. On the other side of the room, the target sheet of paper, coated with barium platinocyanide, began to glow brightly—despite the fact that the vacuum tube had been insulated with the black cardboard.

The German professor further discovered that a huge textbook interspersed between the vacuum tube and the barium platinocyanide paper also failed to block the strange radiation that was being emitted. Most extraordinary of all was the physicist’s observation that “if my hand is held before the fluorescent screen, the shadows show the bones darkly, with only faint outlines of the surrounding tissues.”

Wilhelm Konrad von Roentgen, bewildered by the nature of this electromagnetic radiation he had accidentally discovered, called it an x-ray, because “X” had always signified an unknown quantity in mathematics. Roentgen composed only three papers on

Continued on page 33
X-rays, but as a result of his work became the first Nobel Laureate in Physics (1901). He donated all of his prize money to the University of Wurzberg.

Not long after Roentgen’s seminal paper, Thomas Edison began experimenting with modified Crookes’ tubes, using them as light bulbs and calling them “fluorescent lamps.” However, he soon stopped the research. As he wrote: “I started in to make a number of these lamps, but I soon found that the x-ray had poisonously affected my assistant, Mr. Dally, so that his hair came out and his flesh commenced to ulcerate. I then concluded it would not do, and that it would not be a very popular kind of light, so I dropped it.”

Mr. Dally died in 1904 at the age of thirty-nine, the first recorded fatality from man-made ionizing radiation.

One final note. The specific reason for which Sir William Crookes had developed his vacuum tube was to measure the mass of a newly discovered trace element. The vacuum tube would allow precise weighing of extremely small amounts of any substance, without the confounding buoyancy of air. Crookes had earlier discovered the new trace element in a sample of selenium ore. By spectroscopic analysis of the ore, he had observed a beautiful, thin, green line that did not correlate with any known substance. Crookes named the new element from the Greek word thallos meaning “a green twig.” He called it Thallium.

Barton J. Gershen, MD, Editor Emeritus of Maryland Medicine, retired from medical practice in December 2003. He specialized in cardiology and internal medicine in Rockville, Maryland.
“I asked him how he was. His last words were, ‘I’m having the time of my life.’ I think he was being sarcastic.”
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