

THE MARYLAND
familydoctor SUMMER 2009

The official journal of the Maryland Academy of Family Physicians

**PALLIATIVE
MEDICINE:
NOT JUST
END-OF-LIFE CARE**

Palliative Medicine: To Provide Comfort Always

The Horizon Ahead in Palliative Cancer Care Clinical Research Methodology

"Doctor, Honor My Wishes," Maryland's Health Care Decisions Act

ALSO...

- Quarter Century Girl
- Poetry of Life

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editor



Palliative Medicine: Still An Enigma to Many of Us

by Jasmine Chen Gatti, M.D.



DOES THE TERM PALLIATIVE medicine bring to mind thoughts of sadness and dying, thoughts of futile treatments, vague regulations and non-evidence-based research?

This summer edition of *Maryland Family Doctor* brings a fresh perspective to this often times misunderstood specialty that has just received ABMS and AAFP certification. Along with a new perspective on a brand new specialty in an arena long practiced by founding hospice pioneers such as Ciercely Saunders, this edition will provide some practical pointers for your practice and inform about the legal and research aspects of this evolving field.

Dr. Supanich's article on "Palliative Medicine: To Provide Comfort Always" will offer insight for daily practice. Dr. Nay's article on the importance of advance care directive discussions and the Health Care Decisions Act complements Dr. Amin's article on "The Horizon Ahead in Palliative Cancer Care Clinical Research Methodology..." charging us with the needs that still are apparent in this field.

We hope this edition will continue to emphasize what a wonderful privilege it is to be family physicians who can impact our patients from the time of their birth to the time of their death, and of course, very much in the times in between. ■

Dr. Gatti is boarded in Family Medicine, geriatrics and palliative medicine. She currently has a home visit and geriatrics practice and works for FDA. She edits this, her 3rd edition of *The Maryland Family Doctor* since joining the MAFP Editorial Board in 2004. She lives with her husband and children in Bethesda.

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executive director



Quarter Century Girl

Barr Receives National Honor from the American Academy of Family Physicians

by Esther Rae Barr, CAE

KANSAS CITY, Mo. – Esther Rae Barr, CAE, executive director of the Maryland Academy of Family Physicians from Baltimore, MD., was presented the 2009 Executive Service Award by the American Academy of Family Physicians (AAFP) at its Annual Leadership Forum (ALF) meeting April 25 in Kansas City. The AAFP's Executive Service Award recognizes chief staff executives who have served their Chapters for 25 years or more, contributing significantly toward the advancement of Family Medicine....

THANKS TO THE AAFP for presenting to me an Executive Service Award (ESA) for 25 years of employment with and service to the MAFP and for putting out a press release about it (excerpt above). This is quite an honor, and the ceremony in Kansas City during ALF was a fun, memorable event; mostly because I shared the spotlight with three fellow chapter executives also being honored that day. My colleague Carla Coleman of the Arkansas Chapter was a co-recipient of the ESA. Both Carla and I began our careers with our chapters and the AAFP 26 years ago in 1983 (gasp!). In addition, receiving the AAFP's Awards of Merit (after being nominated by their chapters) were Carolyn Gaughn of the Kansas-AFP and Vito Grasso of the New York-AFP.

By and large the chapter executives network is a tight one, made up of a professional, dedicated and capable group of folks who essentially work at the same job in their home states. I am one of those 54 individuals who make up a diverse collection of people in varying stages of career, with divergent backgrounds, education and credentials who, along with their chapter leaders, have basically the same professional mission – to further the specialty of Family Medicine for the benefit of our members and their patients. Considering that most chapter execs I know prefer to be behind the scenes assisting their organizations' volunteer leaders realize success as they aspire to their organizational missions, this front-

and-center event was a great opportunity for us to shine; as well as to bring to the national audience positive attention to our and our chapters' achievements.

I do want to acknowledge and thank my husband and two children (now quite grown) who have served as extended MAFP staff through the years. I really couldn't do this job without their love and support. Also, the wonderful group of leaders and members whom I continue to serve make it a continually fulfilling professional life.

Another fine experience for me during ALF was my partnering with MAFP President-Elect Dr. Eugene Newmier of Cambridge at an all-day "Elected Leader/CEO Forum,"



2009 AAFP Chapter Executive Award Recipients (l-r): Carla Coleman, AR; Carolyn Gaughn, KS; Vito Grasso, NY; Esther Barr, MD.



Esther Barr is presented the 2009 AAFP Executive Service Award by MAFP Immediate Past President Dr. Jos Zebley (l) and AAFP President Dr. Ted Epperly.

which covered such important topics as the roles of elected leaders/boards of directors, the roles of management/staff, aspects of organizational operations and vision/mission/value statements. The session leader, Bob Harris, an expert on all things association related, led the 6-hour session which, believe it, flew by. The session was quite interactive as chapter execs and leaders readily shared experiences (good and bad) that we all have learned from.

During the segment on organizational mission statements, Bob shared various ones from the AAFP and several chapters, as well as other organizations. I, not being able to help myself, offered that the Maryland Chapter has a 7-word mission statement which was arrived at after a series of facilitated working group sessions taking place over a 5-year period. After a few chuckles from the group he asked me to share the seven words, to which I responded, "Able, Responsive Family Physicians Serving Their Communities." He wrote it on the flip chart and it stayed visible for the entire length of the session. At the end of the day, he came over to me and Dr. Newmier, handing me a gift, the book *"The Perfect Board,"* by Calvin Clemons, for having, as he stated, "the best mission statement of the day." This was a prideful moment. No one chapter is strong in every area, but it's nice to think that the Maryland chapter got this one right! My aim is to continue on, along with MAFP members and leaders, in aspiring to our mission. ■



Palliative Medicine: To Provide Comfort Always

by Barbara Supanich, RSM, M.D., FAAFM, FAAHPM



IT IS MY FIRM belief that Family Medicine and Palliative Medicine combine the ideal set of skills which each day in the state of Maryland and around the world provides care for those with a chronic illness and their circle of intimate supporters.

As Family Medicine physicians, we are trained not only to have a broad, competent and evidence-based knowledge of medicine, surgery, ob-gyn, psychiatry and pediatrics, but even more importantly in my estimation, we learn about family dynamics, family systems and key communication skills in our residency training. This knowledge base and personal relational skills are the value-added aspect of Family Medicine for our patients and their families. So, what can palliative medicine offer to you?

Defining Palliative Medicine

Now recognized by the ABMS, the AAFM and ABFM, Palliative Medicine is the medical subspecialty that trains physicians to develop a partnership between physicians and patients living with chronic illnesses, focusing on patient goals of care and their understanding of quality of life

for themselves and providing expertise in the management of pain and other distressing symptoms. Specialists focus on listening to the patient's experiential story of their illness and how it affects their lives, and then develop a treatment plan that meets the needs of patients and their families.

Who is Eligible

Palliative Medicine can be provided to people of any age with any chronic disease (CHF, COPD, hepatic failure, renal failure, CVI, ALS, AIDS, Sjogren's, Cancers, etc); when patients, families or friends have a desire to integrate palliative medicine therapies and support with their usual therapies to manage their disease; in any setting where the patient is receiving care (home, hospital, palliative care units, hospice, LTC, SNF, OP Palliative Care Clinics, physician offices, etc); and with the patient's primary care health team.

Myths

Many people think that Palliative Medicine is identical to hospice care or "end-of-life" care. But while it certainly includes the provision of excellent hospice care, Palliative Medicine is much broader.

Teamwork and the Spectrum of Care

Palliative Medicine consults can be ordered at the time of a serious diagnosis

– MI, Type 1 or 2 DM, CHF, COPD, CVI or cancer. Palliative treatments and supportive care can be blended with the usual active treatments for these illnesses. As Family Medicine physicians, we know that this type of care is best provided as a team of specialists, other professionals, the patient and her/his family/friends – the composition of which is determined by patient goals and medical needs.

Our approach in Palliative Medicine is comprehensive and cooperative. As a team (physician, BSN coordinator or nurse-practitioner, social worker, chaplain), we use our conversational and professional skills to identify the patient's and a family member's understanding of the illness, how it is affecting them personally, socially, professionally, emotionally, spiritually and in their relationships with key people in their lives. We are then able to identify the patient's goals of care, be they medical, personal, spiritual or legacy goals.

If the person is having significant pain, nausea, shortness of breath, constipation, weakness or anorexia, the palliative care team can offer recommendations.

If the person's physician has asked for assistance with advance care planning, transition of care into hospice care or assistance with helping the patient cope with a terminal illness, then the skills of

continued on page 8

a social worker and/or spiritual care professional are invaluable.

The spectrum of Palliative Medicine has three main categories:

Active Management: Palliative Medicine sometimes involves the care of the patients while they are receiving active treatments that modify or attempt to cure their disease. The team can provide emotional support, spiritual support and relief from symptoms related to the active treatment, e.g., steroids for tumor edema, ginger for mild nausea medications for pain management, goals of care discussions, etc.

Urgent Symptom Management: Symptoms associated with treatments, side effects of treatments or advancement of the disease include: pain crises (level 4/10 or greater), severe dyspnea, moderate to severe anxiety, terminal restlessness, severe nausea and vomiting, seizures or sudden and/or unusual changes in mental status. The palliative team can assist with the management of these symptoms whether the patient is in the hospital or at home.

Comfort Treatments: Comfort is a goal of care for most patients throughout their lifetime. In particular, patients want us to assure their comfort (as they define comfort) throughout their serious illnesses, when they are starting a major decline and have new symptoms and when they start to die from their serious illness. The spectrum ranges from administering medications to relieve acute or chronic symptoms, providing appropriate counseling for emotional symptoms or spiritual angst, or using relaxation methods, meditation, imagery or other non-pharmacologic approaches. I have witnessed patients experience relief from distressing dyspnea or pain because a close friend or family member is reading a favorite story to them or singing a soothing song.

As Family Medicine physicians, we know that this type of care is best provided as a team of specialists, other professionals, the patient and her/his family/friends – the composition of which is determined by patient goals and medical needs.

Questions To Ask When You are Ready To Refer

Have you identified and documented major changes in the natural history of your patient's illness such as:

- Decreasing or little efficacy of standard treatments
- A change in the patient's personal experience of their illness (They notice they are not improving or maintaining their usual level of activities, or their meds are no longer as effective, or their stamina, appetite and sleep are markedly in decline.)
- The patient or a family member or you notice that there are significant changes in the usual family dynamics or interactions (The patient is more isolated socially or family members are isolating themselves from the patient.)

You might also ask yourself, "Would I be surprised if this patient died within the next year?"

A patient-oriented statement to invite further discussion might be, "Now that we have discussed these new findings (lab or radiologic studies, pt's sharing their personal experience of their illness), would you share with me the most important concerns you have today?"

Treatment Goals

Palliative Care teams are often asked to have a conversation with the patient and family regarding clarification of treatment goals. The following is a brief outline of how I approach such conversations.

One of the main goals of such a discussion is to share information – the patient and/or family members share their experiences and concerns and I listen and share possible strategies, treatments, or approaches. Interestingly, my experience is that most patients want to know their prognosis – some for planning purposes (not only finances, wills, etc, but also travel, visits with friends, conversations with important family members, etc.). When I have shared a prognosis with a patient, I usually phrase it something like this: "You have shared with me that you have noticed that in spite of taking your current heart (or lung or cancer) medications, you have not regained the strength or appetite you were hoping to regain. When this happens to a person with your diagnosis, we know that on average, a person has a prognosis of four to six (months, weeks, etc). Some live a little longer, some live a bit shorter." I then pause and let the person "absorb" this information. The next part of the conversation depends upon their response, but I always provide reassurance, support and hope.

As a team, we also work with the patient and family in answering their concerns regarding disease progression, effects of disease progression on their lifestyle, adequacy or inadequacy of current treatments for symptom relief and the patient's readiness to reconsider current treatment goals.

When your patient is exhibiting physical signs of end-stage illness, significant physical decline or is not responsive to curative treatments, these are crucial times to discuss palliative care or hospice care as a very reasonable approach for the provision of comprehensive and compassionate care.

As Family Medicine physicians, we understand the contextual nature of our patients and the various elements that influence their illnesses. We are usually attuned to family dynamics and how they are influencing our patient's lives and relationships. This knowledge we gain of relationships in our patients' lives is invaluable when we embark on a conversation regarding treatment goals of a person with a terminal illness. ■

Suggested Readings

1. Storey, P and Knight, CF. American Academy of Hospice and Palliative Medicine UNIPAC Series. 2009, 2003. Mary Ann Liebert, Inc Publishers.
2. Improving Care for the End of Life: A Sourcebook for Health Care Managers and Clinicians. Lynn J, Schuster, JL, and Kabcenell, A. New York: Oxford University Press, 2000.

Annotated Websites

1. American Academy of Hospice and Palliative Medicine: www.aahpm.org This is the official website for physicians who practice hospice care or palliative care. It has many good links to professional information and other educational materials for professionals and patients.
2. Center to Advance Palliative Care: www.capc.org. Excellent website for information on palliative care for professionals, for those interested in starting or maintaining a team, billing information, educational materials, etc.
3. Holy Cross Hospital Palliative Care Web: <https://hch.palliativecare.webexone.com>. This is the website of the Holy Cross Palliative Team. It has many excellent links for patients and professionals and information on CME sessions at Holy Cross on palliative care, etc.

Dr. Supanich is medical director, Palliative Care/Seniors, Holy Cross Hospital in Silver Spring, Maryland.

calendar



2009

- June 17-20 MAFP Annual CME Assembly & Trade Show
Clarion Resort Fontainebleau Hotel & Conference Center
- July 30-August 1 AAFP National Conference of Family Medicine Residents and Medical Students
Kansas City
- August 20-22 Southeast Family Medicine Forum (invitational)
Historic Inns of Annapolis
Annapolis

2010

- February 20 MAFP Winter Regional CME Conference
Sheraton Hotel
Columbia
- June 23-26 MAFP Annual CME Assembly & Trade Show
Westin Hotel
Annapolis

AAFP Scientific Assembly Schedule

2009	October 14-18	Boston
2010	September 29-October 3	Denver
2011	September 19-21	Chicago
2012	October 15-17	Philadelphia
2013	September 23-25	San Diego

Correction

Members are directed to the following item which appeared incorrectly on p. 24 in the Spring, 2009 edition of *The Maryland Family Doctor* publication. The edition item, "Bylaws Change" did not highlight deleted language. The Bylaws change was voted by members present at the 2009 MAFP Annual Business Meeting on Friday, June 19, at the Clarion Hotel in Ocean City, MD. Please note the corrected segment below:

Bylaws Change

Key: **shade = delete**, **underline** = new language

Note: Due to increasingly complex accounting practices and resulting skyrocketing costs of full financial audits, the change would call for full financial audits at the determination of the Board rather than at set intervals. Currently, an annual compilation is performed.

CHAPTER XX - STANDING COMMITTEES

Section 2. Finance Committee. The Finance Committee shall be composed of the Treasurer of the Maryland Academy of Family Physicians and two (2) or more members appointed by the President. The Treasurer shall be the chairman of this Committee. Except in the case of death or resignations, no more than two (2) members of the Committee should be replaced in any one year. This Committee shall supervise the keeping of this organization's accounts, submit an annual budget for the approval of the Board of Directors and arrange for a compilation of accounts annually as well **as for a full financial audit at five (5)-year intervals or more frequently as ordered** more extensive financial audits as determined by the Board. Accountants performing services for the organization shall be recommended by the Finance Committee and approved by the Board.

Next Edition Continuing to Weather the Storm



The Horizon Ahead In Palliative Cancer Care Clinical Research Methodology

Have I Done The Best I Could for My Terminally Ill Cancer Patients or Can I Do Better?

by Shilpa H. Amin, M.D., Msc, FAAFP

Every person is like all others, like some others, like no other. Buddhist proverb



“OH, BY THE WAY, did you hear? Ms. K died last week.” The nursing assistant uttered these words in passing as the elevator doors closed. I couldn’t believe it. Her transfer hospital records five days prior reported a stage II ovarian cancer. She had been recovering in sub acute rehab following the revolving door of hospitalization to/from the nursing home. Most recently

she had sustained a humeral fracture compounded by a resilient case of clostridium difficile thriving in her intestine. I re-wound the tape in my mind of the days, weeks and months of her presentation, the course of her care, her pleasant disposition amidst the fatigue, hardly dyspneic with mild abdominal bloating, a sore lower back and arm from the fracture. Her long-acting and qid short-acting pain regimen seemed to suffice, or did it? Her last ‘glow’ was my most vivid snapshot before I left on vacation. I didn’t anticipate she would suddenly die, surely she had a few more weeks. Was she comfortable and relieved of her suffering? Did complications or symptoms arise which I didn’t recognize as a result of our medical care or conditions? Did I do everything I should have or too much? How were the moments leading to her death?

Health Performance Measurement Tools Should Reflect Clinical Principles of Good Care

Five hundred thousand cancer deaths occur in the U.S. each year, and up to 70 percent of patients are estimated to suffer from pain as one of several established symptoms at the end of life. At the micro level, the provider asks these kinds of real world questions every day, while at the macro level, the health care system, including federal, private and academic research partners and organizations, are now actively examining this given the sobering fact that

pay for performance is becoming an integral reality of our approach to health care delivery and, in fact, a part of consumers’ decision-making choices. Health performance measurement tools need to directly reflect clinical principles of good care in order to guide and improve the care process between providers and patients.

Benchmarks for Overuse and Underuse of Care

Measurement of end of life care can be divided into those that assess overuse of aggressive care to identify complications of care (i.e., chemotherapy, acute care hospitalization) and to those that measure underuse of palliative services (i.e. hospice, opiates). These measures have to be understood in terms of the type of approach utilized in assessing end of life care delivered - retrospective (looking back at care delivered after death) vs. prospective (looking forward as care is delivered).

Setoguchi et al. conducted a cohort study which compared prospective (period of 14 months from cancer diagnosis) and retrospective time periods (period of 14 months before death) and defined opiate benchmarks to assess end-of-life care by examining linked claims and cancer registry data in New Jersey and Pennsylvania for seniors 65 and older with breast, colorectal, lung or prostate cancer. They demonstrated that select indicators in hospital-based systems, such as opiate benchmarks (i.e. proportion of patients who received an outpatient prescription for a long-acting opiate; a short-acting or long-acting opiate; or both a short acting and long-acting opiate) of under use of palliative services are relevant and quite similar for understanding quality of care through both time period approaches.

Chemotherapy initiation at the onset of a cancer diagnosis may be common and part of the supportive care process, therefore, it is not necessarily an indicator of aggressive care, whereas the receipt of last chemotherapy and treatment related toxicity in conjunction with an admission to the emergency department and admission to hospice within three days of death are potentially identifiable complications of aggressive care. Both approaches of evaluation identify analogous physician and hospital patterns at the end of life

analyzed by specialty (i.e. oncology vs. primary care) and practice size (small vs. large group). However, retrospective reviews, while efficient, can lead to bias if patients who are expected to die actually recover. Likewise, they may facilitate in the identification of terminally ill populations who need more quality improvement initiatives in end of life care. Prospective reviews may be more amenable to actionable interventions for improvement and provide better determinants of patient 'prognosis,' a common assessment dilemma of most primary and subspecialty healthcare providers.

Lorenz et al conducted a 2008 update to the 2004 NIH State of the Science evidence review and the 2005 ACP clinical guidelines which assessed the evidence-based literature on improving palliative care at the end of life. Three specific clinical conditions (cancer, dementia and heart failure) and topics related to palliative symptoms such as pain, dyspnea, depression and care issues were explored: advanced care planning, continuity and care giver concerns. The review found that while there was variable literature which carefully indexed for advanced chronic illness and end of life care, this limited the comprehensive information available to address the key questions about elements and strategies of providing palliative care. There was strong-to-moderate evidence supporting specific interventions in end of life care (i.e. treating cancer pain with opioids, nsaid, radio nuclides, radiotherapy; short-term opioids for dyspnea and chronic lung disease; cancer-associated depression with psychotherapy, tricyclics, and selective serotonin reuptake inhibitors; multicomponent interventions to support care coordination in congestive heart failure patients and the facilitation of advanced care planning).

Quality Indicators Useful to Meet Optimal Health Care

An important message of this review was that the future research agenda needs to succinctly evaluate the effects of these elements across conditions and settings. In other words, 'quality' is the focal point in this evaluation. Quality indicators in health care are endpoints which measure quality of a process (how care is delivered), the setting and infrastructure (how is the environment of care delivery) and end-product or outcome (what are the sequelae, what happens) in the population subgroup being assessed (ie. terminally ill).

In 2001, the Institute of Medicine, an independent body, made recommendations in their cornerstone publication, "*Crossing the Quality Chasm*," and mandated the societal investment and development toward six dimensions of "quality" in order to meet optimal health care in the U.S. which is safe, effective, timely, patient-centered, efficient and equitable. The National Quality Forum conducted a 2006 systematic review, *A National Framework and Preferred Practices for Palliative and Hospice Care Quality*, which highlighted the disparity between the current evidence (what we know) on the efficacy of current tools and interventions to

improve supportive care and the deficiencies (what we don't know) in understanding quality of palliative care delivered. This report, along with the National Consensus Project, were initial steps taken to identify broad clinical domains (structure, process, physical, psychiatric, psychosocial, spiritual /religious, cultural, care of imminently dying, ethical and legal, delivery of care) in palliative medicine and to define standard preferred practice measurements using specific evaluation criteria for quality indicators (importance, scientific acceptability, usability, feasibility) as one branch of the IOM's overarching 'quality' recommendations. Overall, the challenge lies in identifying and implementing quality indicators to measure end of life care and support quality improvement as there are few randomized controlled trials conducted in this area and this type of care in health delivery settings is not well-documented in health care settings (i.e. practices, nursing homes, skilled-nursing facilities, etc.) to allow extrapolation and analysis of the validity of select end of life measures. This work relies on initiatives such as expert consensus opinions and outlining recommendations to be tested in clinical settings for validity.

The Cancer Care Quality Measurement project (CANQUAL), a consortium of NCI and federal agencies reviewing research of end of life quality indicators, identified specific measures in the quality of cancer care which had demonstrated scientific validity and generalizability in cancer care populations. It carefully considered a 2006 AHRQ-sponsored evidence report on cancer care quality measures, laying out the issues related to assessment of those quality indicators specific to cancer care in order to develop and apply a process for 'field' testing of measures in relevant populations at various stages of disease state and settings. ASCO is already working on a Quality Oncology Practice Initiative (QOPI) to begin physical domain quality indicators of 'dyspnea' into clinical practice.

AHRQ and NCI have commissioned a follow-up research report due this year which explores the development of a 'framework' to integrate all of the prior work to understand quality indicators in the scope of end of life care domains specific to cancer care in order to further refine, develop and to devise strategies to pilot for implementation in practice settings. Several validated evaluation tools (ie Cancer-Quality-Assist tool) for quality indicators in the 'cancer care continuum' are also being reviewed.

Most recently, Lorenz and colleagues have published their work of the ASSIST (Addressing Symptoms, Side Effects and Indicators of Supportive Treatment) Project, which specifically characterizes pain and nonpain symptom evaluation in cancer care and have developed direct 'process'-quality indicators surrounding: pain, depression, dyspnea, nausea and vomiting, fatigue and anorexia, other treatment toxicities, information and care planning needs that would be useful for primary care physicians, oncologists and palliative care clinicians to assess patients' quality of life.

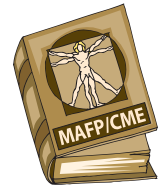
continued on page 20



“Doctor, Honor My Wishes”

Maryland’s Health Care Decisions Act

by Patricia Tomsco Nay, M.D., CMD, CHCQM, FAAFP, FAIHQ, FAAHPM



THE DISCUSSION OF PROVIDING, withholding and withdrawing treatments at the end of life evokes strong emotions. For some, it is a personal liberty not to be infringed upon by the state or physicians. For others, it is an issue of the sacredness of human life that should be protected by the state¹. In Maryland, the law protects the patient’s right to accept or decline treatments at the end of life.

A crucial role of the physician is that of patient educator, explaining the burdens, risks and benefits of treatment options to help patients make informed decisions. But when patients can no longer communicate their wishes, what guides the physician? There may be an advance directive outlining the patient’s wishes regarding treatments. Patients may also have designated a health care agent to speak on their behalf. If there is no designated health care agent, a surrogate decision maker is used.

On May 12, 1993, Maryland Governor William Donald Schaefer signed the Health Care Decisions Act into law. The

law went into effect on October 1, 1993.² Professor Diane Hoffman, University of Maryland School of Law, noted, “This law is clearly a step forward for Maryland citizens that will allow them a greater role in decision making regarding their medical treatment.”¹ This law is one part of the complex process of assuring that patients receive the end-of-life care they desire. A crucial part of the process is the role of the physician who cares for the patient near the end of life. It is essential that this physician discuss treatment options with the patient. If the patient can no longer make these decisions, then their advance directive speaks for them. Advance directives are a way to “listen to the patient” when patients can no longer speak for themselves.

In Maryland, an individual may make a written, electronic, or oral advance directive. A standard form is found on the attorney general’s website³ or a different format can be used. A written or electronic advance directive requires two witnesses. A physician, nurse practitioner or other health care worker can be a witness. The health care agent cannot sign the document as a witness. One of the witnesses must not financially benefit from the individual’s death. An oral advance directive and/or appointment of a health care agent may be given to the attending physician or nurse practitioner in the presence of a second witness. All forms of advance directives should be placed in the patient’s medical record. A competent patient may revoke an advance directive at any time with a subsequent written

or electronic document, by destroying the document or by an oral statement to a health care practitioner as outlined above.

As family physicians, we sometimes care for very ill patients who can no longer understand the burdens, risks and benefits of treatments or cannot communicate decisions. We then turn to their advance directive for guidance. Unless otherwise specified, the advance directive becomes effective when the attending physician and a second physician certify in writing that the patient is incapable of making an informed decision. If the patient has designated a health care agent, then that individual becomes the decision maker. If there is no designated health care agent or the agent is unavailable, the law specifies the type and order of surrogate decision makers.

In the following order, the surrogate decision maker is the (1) guardian, (2) spouse or domestic partner, (3) adult child, (4) parent, (5) adult brother or sister and (6) friend or other relative. A friend or other relative must present an affidavit demonstrating that he or she has had regular contact with the patient and is familiar with the patient’s activities, health and personal beliefs. This affidavit should be placed in the patient’s medical record. If everyone in a class is unavailable, go to the next class of surrogates. If persons in the same class disagree and the patient is in a hospital, nursing home or related institution, the case should be referred to a patient care advisory committee. The physician is not liable for any claim based

on lack of consent if the physician acts in accordance with the recommendation of the patient advisory committee. If the patient is not in a hospital, nursing home or a related institution, a physician may not withhold or withdraw life-sustaining procedures if there is disagreement among all persons in the same class.

Physicians are sometimes faced with a health care agent who makes a choice that contradicts the patient's written advance directive. A common scenario is a patient with end-stage dementia who is dependent for all activities of daily living. The patient's advance directive clearly and unambiguously states that she does not want any artificial feeding or hydration and specifically no feeding tube. The document further states that the health care agent must follow her wishes. Her daughter is her health care agent and she insists that a feeding tube be placed. In Maryland, this patient's clear and unambiguous advance directive must be followed.

When a health care agent has not been appointed and a surrogate decision maker is being used, health care providers may not withhold or withdraw life-sustaining procedures until an attending physician and a second physician have certified that a patient is in a terminal condition, end-stage condition or persistent vegetative state. If the patient is unconscious or cannot communicate by any means, a second physician's certification is not required. An end-stage condition is an advanced, progressive and irreversible condition. The individual is dependent for all activities of daily living and there is no effective

treatment for the underlying condition. A terminal condition is incurable and there is no recovery despite life sustaining procedures. Death is imminent (as defined by a physician). In a persistent vegetative state, the individual has no awareness of self or surroundings. One of the two certifying physicians must be a neurologist, neurosurgeon or other physician with special expertise in evaluating cognitive functioning.

A physician is not obligated to offer therapy to a patient that is medically ineffective, including cardiopulmonary resuscitation. Medically ineffective treatment is a medical procedure that will not prevent or reduce the deterioration of the patient's health or prevent impending death. A patient's capacity to make medical decisions may vary over time and depends on the complexity of the decision; but to the fullest extent possible, the patient should be included and informed of the plan of care. The health care agent or surrogate decision maker(s) should also be informed. If two physicians decide that cardiopulmonary resuscitation is not medically effective in an end-stage dementia patient who is unable to communicate, the health care agent or surrogate decision maker should be informed of this decision and the physicians should be prepared to explain the rationale for this decision.

The Health Care Decisions Act affords legal protection to physicians and nurse practitioners that follow it. A health care provider is not subject to criminal prosecution or civil liability or deemed to have

engaged in unprofessional conduct by withholding or withdrawing health care in accordance with this law. There are penalties if any person conceals an individual's advance directive and causes life-sustaining procedures to be used in contradiction of the patient's expressed wishes. In Maryland, this is a misdemeanor with a fine up to \$10,000 and/or imprisonment of up to one year.

The Office of Health Care Quality is Maryland's licensing and regulatory agency. Its mission is to oversee the quality of health care in 8,000 facilities and to protect the health and safety of Maryland's citizens. Noncompliance with the Health Care Decisions Act can result in deficiencies, fines and other remedies. The Health Care Decisions Act applies in all health care facilities and settings. The Office of the Attorney General and the Office of Health Care Quality are part of a larger process that helps to ensure that your wishes are followed regarding end of life care. For additional information on the Health Care Decisions Act, go to the websites of the Office of the Attorney General³ or the Office of Health Care Quality⁴. ■

Dr. Nay has a palliative medicine practice in Montgomery County. She is the part-time medical director of Maryland's Office of Health Care Quality.

¹ Hoffman, Diane E. (1994). The Maryland Health Care Decisions Act: Achieving the Right Balance? *Maryland Law Review*, 53(4): 1064-130.

² Annotated Code of Maryland, Health General Article, § 5-601.

³ <http://www.oag.state.md.us/Healthpol/index.htm>

⁴ <http://dhmh.state.md.us/ohcq/download/alerts/alert-v1-n1-sum2002.pdf>



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**A Message for Healthcare Providers Who Diagnose
and Treat Patients with
High Blood Pressure**

From

The Maryland State Advisory Council On
Heart Disease and Stroke

**A "Simple Strategy" to Help Your High Blood Pressure Patients
Achieve and Maintain Recommended Levels of Control**

**Every single time you give a patient a prescription
for a blood pressure medication,
remember to say:**

- ♥ "High blood pressure is a chronic disease. It cannot be cured;"
- ♥ "This medication will **control** your high blood pressure when you take it **exactly** as I have indicated;"
- ♥ "You must **plan ahead** to refill your prescription so you do not have to skip any doses."

[Watch for Another "Simple Strategy" Next Month](#)



Poetry of Life

by Carol Dwan, MS III

University of Maryland School of Medicine



Editor's Note: One of the talks that all third year University of Maryland School of Medicine Medical Students receive when they rotate through the Department of Family and Community Medicine is entitled "The Poetry of Life." This is based on a quote by Sir William Osler which follows:

"Nothing will sustain you more potently than the power to recognize in your humdrum routine, the true poetry of life - the poetry of the commonplace, of the ordinary man, of the plain, toil-worn woman, with their loves and their joys, their sorrows and their griefs."

This past month, one student was excited to recognize what she identified as "poetry of life" in one of her patients and took the time to put her thoughts into print. I share this account by third year medical student Ms. Carol Dwan from Annandale, VA, to remind us of the passion that our students have for our patients.

*Richard Colgan, M.D.
Editor-In-Chief, The Maryland Family Doctor
Director, Undergraduate Education
Department of Family and Community Medicine
University of Maryland School of Medicine*

DR. COLGAN, I HAD my first poetry of life case today! I just thought you'd be interested. Here's the bit I wrote about it:

In that vein, we had a very touching case stuffed in at the end of an otherwise normal day in primary-care-land. At 4:10 a secretary came back and asked if the doctor I was working with could see a patient who had come in late. The doctor was with a patient and the secretary waited patiently for 20 minutes, all the while saying "They're really a sweet family...they drove from very far away and got turned around, so that's why they're late." Everyone else at the station nodded and could neither confirm nor deny that they would be seen. The doctor came out and said "sure." She took the chart which said "Huntington's disease" as the chief complaint. She showed us and said "I have never seen a case of this. This is amazing." The second year student and I followed her in.

The patient spoke no English, but her husband did. They weren't much older than me. The patient was seated on the exam table moving around like she couldn't get comfortable. These are "choreaform" movements, characteristic of the disease along with gradual mental decline. It is a progressive, lethal disease with no known cure. Horrible! The doctor spent a bit of time trying to piece the story together through the husband and a translator. She eventually took her glasses off and asked the husband how much he understood about the disease and what to expect. She asked him about his resources and who could help him with his four children. Then, all of a sudden, for me this was no longer an article in medical school, no longer a punnett square. I thought two out of those four little faces looking at me may already have this same fate and may be writhing on exam tables themselves in a few years.

We were able to confirm that the patient had an appointment arranged with the chair of neurology in May. My doctor left a message with her old doctor asking for more info and saying that she would call the pediatric clinic to try and get the kids in to be tested themselves. They are uninsured; two are citizens, the mother and the other two children are not. The father is currently unemployed. One of the medicines costs \$1,060 a month.

When asked what his biggest concern was the patient's husband said, "It is very sad... I love my wife very much and it is too sad for her to be suffering. It is hard for me." He cooks food for the day, sends the kids off to school, goes out to look for a job, then comes home when the kids come home. I can't even imagine the stress he is under... and looking at a steadily declining future, the sure loss of his love and partner.

Family doctors don't just treat colds. They don't just refer. They are the home base, the ones who take responsibility for you, who will sit with you for two hours at the end of the work day when their feet are burning and their own family is waiting at home. They are social workers, psychologists, physicians and friends. ■

journal cme quiz



Articles:

1. Palliative Medicine: To Provide Comfort Always p. 7
2. The Horizon Ahead in Palliative Cancer Care
Clinical Research Methodology p. 10
3. "Doctor, Honor My Wishes"
Maryland's Health Care Decision Act p. 12

The Maryland Family Doctor has been reviewed and is acceptable for up to 4 Prescribed credits by the American Academy of Family Physicians (AAFP). AAFP accreditation for the current cycle began on **October 1, 2008**. Term of approval is for two years from this date. This **Summer, 2009 edition (vol. 46, No. 1)** is approved for 1.25 Prescribed credits. Credit may be claimed for two years from the date of this edition. Note: total per-edition credit over the course of this term is subject to change based on topic selection and article length.

AAFP Prescribed credit is accepted by the American Medical Association (AMA) as equivalent to AMA PRA Category 1 credit toward the AMA Physicians Recognition Award. When applying for the AMA PRA, Prescribed credit earned must be reported as Prescribed credit, not as Category I.

NEW CREDIT REPORTING PROCEDURE: To obtain the credit certificate, complete and return the post-test (CME quiz) directly to the Maryland Academy of Family Physicians. Beginning with the Winter, 2009 edition, MAFP staff will report credits to the AAFP for those members who return completed quizzes to the MAFP office. Each member will receive a confirmation email (or postcard if no email) upon receipt of the quiz forms. Members may check their CME status by logging onto the AAFP website at www.aafp.org Questions? Contact the MAFP office.

Answers p. 22. Instructions: Read the articles and answer all questions by circling the correct answers. Mail, fax or email the quiz form within two years (by January, 31, 2011) to:

Maryland Academy of Family Physicians
5710 Executive Drive, #104
Baltimore, MD 21228
410-747-1980, 410-744-6059 (fax)
info@mdafp.org (e-mail)

Name: _____
AAFP Membership #: _____
Address: _____
City: _____
State: Zip Code: _____
Phone #: _____
Fax #: _____
E-Mail Address: _____

Questions Article #1:

1. As a Family Medicine physician, I can only obtain a Palliative Medicine consultation for my dying patients.
A. True
B. False
2. The patients who truly benefit from palliative care are cancer patients only.
A. True
B. False
3. Palliative Medicine physicians are specialists in pain and symptom management of persons living with serious chronic illnesses.
A. True
B. False
4. Palliative Care can be provided while a person is receiving active treatments for their chronic disease.
A. True
B. False

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Questions Article #2:

5. Common treatment-associated toxicities at the end-of-life care include all the following except:
 - A. Dyspnea
 - B. Nausea
 - C. Leukoplakia
 - D. Hiccups
6. NQF and NCP quality domains for hospice and palliative care include all of the following except:
 - A. Treatment-Associated Toxicities
 - B. Care of Imminently Dying
 - C. Psychosocial
 - D. Ethical and Legal
 - E. Physical
7. Chemotherapy initiation at the onset of cancer diagnosis in prospective evaluation is found to be a research quality benchmark indicator of:
 - A. under use of palliative care
 - B. overuse of aggressive care
 - C. overuse of palliative care
 - D. a and b
 - E. none of the above
8. Opioid use in terminally ill patients in both hospital and practice settings and through pharmacy administrative data is a new research quality benchmark indicator of:
 - A. under use of palliative care
 - B. overuse of aggressive care
 - C. overuse of palliative care
 - D. a and c
 - E. none of the above

Questions Article #3:

9. According to Maryland's Health Care Decisions Act, which of the following conditions does not allow a physician to withhold or withdraw life-sustaining procedures?
 - A. End-stage condition
 - B. Terminal condition
 - C. Chronic mental illness
 - D. Persistent vegetative state

10. According to Maryland's Health Care Decisions Act, medically ineffective treatment
 - A. Will prevent impending death
 - B. Will not prevent or reduce deterioration of health
 - C. Is based on a cost analysis and the risk-benefit ratio
 - D. Must first be offered to a patient before withholding the treatment
11. Mrs. Jones has advanced Alzheimer's disease. She is dependent for all activities of daily living, is no longer capable of rational decision-making, and is no longer able to communicate in any way. There is no effective treatment for the underlying dementia. This meets the criteria of:
 - A. Terminal condition
 - B. End-stage condition
 - C. Hospice admission
 - D. Persistent vegetative state
12. In Maryland, a health care agent may contradict the patient's clear and unambiguous instructions in an advance directive in the following situation:
 - A. The health care agent believes the patient did not anticipate this particular situation
 - B. The facility's risk of the health care agent's lawsuit is greater than the penalty for violating the patient's advance directive
 - C. After careful consideration and review by the Ethics Committee, the decision is believed to be in the patient's best interest
 - D. The advance directive clearly authorizes the health care agent to make contrary decisions and/or the instructions were stated to be mere guidance for the agent's consideration
13. If a physician withholds or withdraws health care in accordance with Maryland's Health Care Decisions Act, the physician:
 - A. Is not subject to criminal prosecution
 - B. Is not subject to civil liability
 - C. May not be deemed to have engaged in unprofessional conduct in regards to these specific actions
 - D. All of the above

membership



News For and About MAFP Members

MAFP at 2009 AAFP Annual Leadership Forum and National Conference of Special Constituencies



(L-R) ALF Delegates: MAFP Executive Director Esther Rae Barr, President-Elect Dr. Eugene Newmier, Mrs. & Dr. Jos Zebley; NCSC Delegates Drs. Kisha Davis, Stephanie Davis, Shana Ntiri.

The 2009 AAFP Annual Leadership Forum (ALF) combined with the National Conference of Special Constituencies (NCSC) was held April 30-May 2 at the Hyatt Regency Hotel in Kansas City. During this annual conference chapter leaders, along with the various constituency caucuses, meet and are briefed by AAFP senior leadership, network, elect representatives and put forth policy resolutions to the AAFP Congress of Delegates, which will meet this year in October in Boston. The MAFP delegation: ALF: Eugene Newmier, D.O. (MAFP president elect), Mrs. Esther Barr; NCSC: Stephanie L. Davis, M.D., women physicians; Kisha Davis, M.D., minority physicians; Shana O. Ntiri, M.D., new physicians. Drs. Newmier, Ntiri and K. Davis report:

Dr. Eugene Newmier: I attended the ALF conference on behalf of the Maryland Chapter. I enjoyed this leadership forum and found the resources available to us very helpful. I feel that it is very important for FPs in Maryland to become active as health care reform moves forward. I found networking with other chapter elected leaders to be eye-opening as I learned about the challenges facing FPs in other states around the country. I believe that we are in a unique

position to place Family Medicine back at the fore of American health care. I urge all of us to be active and pro-active. If we are complacent, then we will be left out in the cold and a wonderful opportunity will be missed. If we don't look out for ourselves, no one will do it for us. For FPs, never has "united we stand, divided we fall" rung more true.

Dr. Shana Ntiri: NCSC is an invigorating opportunity to come together with colleagues from across the country to discuss the many issues that are confronting Family Medicine. Serving as the Maryland Chapter New Physician Delegate, I worked with new family physicians (persons who have been in practice less than 10 years or are less than 40 years old) whose practices incorporate the breadth of Family Medicine—surgical obstetrics, urban adolescent care, emergency room and ICU coverage, academics, military service, international health and more. As varied as our futures and our specialty may be, the concerns that face this generation of family physicians are the same. The New Physician Delegation recommended several resolutions for adoption, the majority of which will be presented to the AAFP Congress of

Delegates. The themes raised by the New Physician resolutions included: developing resources for new physicians entering into practice, enhancing residency training, demanding equitable reimbursement for care, implementing EMR and shaping the future of Family Medicine. As a delegate, I contributed to the writing and testifying of a resolution which was adopted on Online Recruitment and Marketing for future family physicians. The energy and passion that was generated through the many conversations and interactions at the NCSC was powerful. It is certainly an energy that all of the delegates in attendance agreed must be carried forward and continued here at home in Maryland.

Dr. Kisha Davis: The minority caucus was very active this year, putting forth 21 resolutions to the AAFP. Several resolutions focused on encouraging minority family physician mentoring to medical and pre-medical students. Other resolutions put forth included asking the AAFP to educate its members about mental health as it pertains to minority populations; increasing physician's civic engagement; education of AAFP members about treatment of opioid addiction with medications such as buprenorphine. A resolution on immigrant health care, which was co-authored by Dr. Kisha Davis, was adopted by the conference and will be forwarded to the 2009 House of Delegates. The take-home message from the conference was that there needs to be increased minority family physician activity in our state and national chapters. I encourage all minority family physicians to mentor a student; encourage adolescent patients to consider medicine or, at the very least, to join the AAFP minority listserv to stay abreast of issues affecting minority physicians and minority patient populations.

International Medical Graduate Caucus: The IMG group advocated for the AAFP to create more resources about Family Medicine for international graduates who may be interested in Family Medicine. The IMG caucus also encouraged the AAFP to advocate for an increase in the number of J-1 visas available in medical shortage areas. These were adopted and will be forwarded to the Congress of Delegates.

Gay, Lesbian, Bisexual, Transgender Caucus: The GLBT caucus put forth several resolutions, including one in support of same-sex marriage. This was adopted by the conference and will be forwarded to the Congress of Delegates.

The special constituency delegation would like to thank the Maryland Academy for allowing us to serve in this fashion. Please contact us via the MAFP office (410-747-1980, info@mdafp.org) to bring forward issues at next year's NCSC.

Appointments, Features, Honors, Special Achievements

Richard Colgan, M.D., Yvette L. Rooks, M.D. and David L. Stewart, M.D., MPH from the University of Maryland Department of Family and Community Medicine co-authored "Increasing Student Interest in Family Medicine and Urban Health Care: The Family Care Tract," which appeared in the Winter, 2009 *Maryland Medicine*.

William D. Hakkarinen, M.D. of Timonium co-presented "Observations on Serum Albumin Levels in Disability Adjudication" at the Quad-Regional meeting of the National Association of Disability Examiners, Niagra Falls, NY, May 6-9, 2009.

William Reichel, M.D. of Timonium (pictured above) reports that the 6th edition of his text was released in February 2009. Since 1999, when the book "*Reichel's Care of the Elderly: Clinical Aspects of Aging*" was named after him, Reichel has been Editor Emeritus. The editors in the 6th Edition are Christine Arenson, M.D., Jan Busby-Whitehead, M.D., Kenneth Brummel-



Bill and Helen Reichel (center) and family.

Smith, M.D. James G. O'Brien, M.D. and Mary Palmer, Ph.D.. The publisher is Cambridge University Press in Cambridge, United Kingdom. The 1st edition of the book was published in 1978. Reichel is affiliated scholar, Center for Clinical Bioethics,

Georgetown University School of Medicine in Washington. He is past president of the American Geriatrics Society.

Editor's Note: Members, tell us of your professional activities, honors, awards, publications, etc. Send to info@mdafp.org.

Glimpses from MAFP's Regional Conference "The Medical Home: Tools for Practice Re-Design and Management," February 21, 2009, Annapolis



Dr. Robert Sprinkle in the lecture hall.



MAFP's special guest Dr. Mary Newman, governor, American College of Physicians of Maryland, chats with luncheon speaker Greg Martin, AAFP state legislative analyst.

Welcome New Members February 16, 2009-May 15, 2009

Active

Yaniv Berger, D.O.
Linwood W. Briggs, M.D.
Melissa Denham, M.D.
Nidi J. Desai, M.D.
Jasmine C. Gatti, M.D.
Nilana S. Gunasekar, M.D.
Shane Hemphill, M.D.
Emily L. Richie, M.D.
Babjide O. Runsewe, M.D.
Ibrahim Salih, M.D.
Linda M. Thompson, M.D.

Kathleen M. Tully, M.D.

Janel S. Wyatt, M.D.

Supporting

Corinne G. Husten, M.D.
Nii L. Lamptey, M.D.
Resident
Adaku U. Orisadele, M.D.
Eric Peterman, M.D.
Catherine Thu Thao Trinh, M.D.

Student

Regina B. Bray
Elaine Bundy
Monica Charpentie
Clair Ciarkowski
Andres F. Correa
Kathleen T. Daly
Mary R. Desi
Nicole Mahdi
Latasha Murphy
Shikha C. Nigam
Danielle M. York

continued on page 20

In Memory

The Maryland Academy of Family Physicians deeply regrets the passing of its member, **Arthur O. Woody, M.D.** (La Plata). MAFP has made a memorial contribution to the MAFP Foundation in his name.

AAFP/MAFP CME Requirements for Active/Supporting Members

Active and Supporting Family Physician Members must accrue at least 150 hours of AAFP Prescribed and Elective credit within each 3-year reporting period, of which: At least 75 must be AAFP Prescribed credit; of which at least 6 of those being obtained from MAFP sponsored programs every 3 years (eg. CME conferences and journal CME).

- At least 25 are from live learning activities
- Not more than 25 are from enrichment activities
- Not more than 30 are from presentation or publication of an original scientific or socioeconomic paper pertaining to medical care
- Not more than 45 are from publication in a state or national "refereed" journal
- Not more than 15 are from preparation and presentation

Members are encouraged to review the document *AAFP Continuing Medical Education Requirements for Members* at http://www.aafp.org/PreBuilt/cme_memberrequirements06.pdf or contact the MAFP office to request a copy; office@mdafp.org.

The AAFP will send Maryland Chapter members, at regular intervals, correspondence showing each member's reported number of hours and reminding members of what is required. All details about the AAFP/MAFP's CME records, reporting and information can be obtained through the AAFP web site at www.aafp.org/cme, toll free at 800-274-2237 (ask for the CME Records Department) or the

MAFP at 410-747-1980; office@mdafp.org (e-mail).

Other Aspects of MAFP CME Policy

The MAFP Board of Directors has approved the following:

1. MAFP members who are faculty members at MAFP conferences may claim the credits for those sessions (even if they are not registrants) for the MAFP CME requirement.
2. MAFP members who are authors of CME articles published in *The Maryland Family Doctor* may claim those credits (according to AAFP policy; www.aafp.org) for the AAFP and MAFP CME requirements.
3. MAFP CME credits will be waived for those Active and Supporting members who relocate to the Maryland Chapter within 6-months of the end of their cycle of AAFP reelection.
4. Active and Supporting members who have not met the chapter requirement to report at least 6 chapter credits within their AAFP reelection cycle may receive a waiver for that cycle, to be made up in the subsequent AAFP Reelection cycle, by following the process noted below:
 - 1) Member must contact the MAFP office submitting a request (written, email, phone call) for a one-time waiver for the chapter requirement indicating a desire to continue membership, pledging to acquire the credits during the next AAFP reelection cycle.
 - 2) Member *must make up* waived credits in the subsequent AAFP reelection cycle (in addition to the required 6 credits).
 - 3) If failing to acquire the required chapter hours in the subsequent AAFP reelection cycle, MAFP will not accept another waiver request from member.
5. The MAFP Board of Directors will consider, on an individual bases, each member failing to meet the chapter CME requirement. The board will determine the course of action for each member in this category. ■

At the front lines, physicians and patients are concerned with the bottom-line and what this means to their practice, working care process. It means those involved in the care team process need to be more engaged and informed on the clinical domains of end of life cancer care (pain, care planning, nausea, vomiting, hiccups, anorexia, fatigue, psychological distress), acquire better diagnostic and actionable tools provided from palliative care teams and reliable evidence-based resources which follow and have critically appraised and translated the compilation of end of life in cancer research to date. More recently, the *Journal of Clinical Oncology* presented a 2008 series of evidence-based standard clinical reviews which details the RAND research described previously and addresses 'symptom' control and management. I will never have the candid view of whether Mrs. K was truly comfortable in her last life moments, but becoming more informed about quality indicators in end of life and cancer care enhanced the palliative focus. ■

*Knowing is not enough; we must apply.
Willing is not enough; we must do.
Goethe*

Dr. Amin is a board-recertified family physician. She is currently a medical officer at the Agency for Healthcare Research and Quality, Center for Outcomes and Evidence, family practice health-care provider with Kaiser Permanente, INOVA Loudoun, Bethesda Naval Medical Center Red Cross volunteer and a supervisory medical director of Minute Clinics in Northern Virginia.

Editor's Note: References for this article appear at www.mdafp.org. Click the "Publications and News" tab.

letters



Pick a Day to Serve in 2010

I WAS PRIVILEGED TO serve as Doctor of the Day this past March 24th. I was able to meet with my House representatives and also sit in on the Senate floor as SB 215, the so-called "False Claims Act" was defeated on third reader. I am, however, disappointed in the number of family docs who served this session. The MAFP no longer has a lobbyist as our board elected to place our emphasis on medical student initiatives and save the significant funds it costs to maintain the legislative representative.

We do, however, need advocacy in Annapolis. Few MAFP members are active in Med Chi (The Maryland State Medical Society), which supports a team of three lobbyists. Who will advocate for Family Medicine if we do not do so ourselves? I know that we are all busy in our practices; I myself have a solo practice. I know an entire day once a year seems to be a huge and overwhelming commitment to the success of our specialty, but I can assure you that even one morning during the session can make a difference.

It's easy. You get free parking for the whole day in Annapolis. You sign in with the nurse and then go up and get introduced in the House and the Senate and get thanked by Michael Bush and Mike Miller. If you wish, you can sit in on the floor of the House or Senate at the press table (Wear a white coat; remember, politics is also theater). If there is a medical bill, your physical presence alone may influence one or two votes. The False Claims Act failed on a vote of 23 to 24!

If you are bored, go back to the first aid room, chat with nurse Colleen White, hand out an ASA (or look at an ingrown nail, as I did) and check a few BPs (always popular).

The general sessions end around noon and the committee meetings and the testimony on pending bills starts at 1300 (1 p.m.). You might be asked to testify on a bill if we need someone to present our case. This can be coordinated with MedChi if need be. You can meet with your legislators to forge new or develop stronger personal relationships. Or you can just cut out and go back to your office or stay for the day and enjoy Annapolis.

So here is a challenge to all MAFP members. Right now, look at your calendars for 2010. January, February, March - 90 days. Commit yourself to spending one business day in Annapolis. Tell your office manager now if you have to clear the absence with a superior. Then when we send out the postcards in October/November, pick a date and go. Dr. Bill Jones (MAFP legislative chair) and I will be glad to give you the scoop on any bills that may be of concern to us. With your participation we can be at the table as the new health plan recommendations come down to the states next year.

I'm counting on you.

Jos. W. Zebley, M.D.

MAFP Immediate Past President
Baltimore



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Answers to Journal CME Quiz p.16

- | | |
|------|-------|
| 1. B | 8. A |
| 2. B | 9. C |
| 3. A | 10. B |
| 4. A | 11. B |
| 5. C | 12. D |
| 6. A | 13. D |
| 7. E | |

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Help your patients embrace the nutrient rich foods approach. Show them that nutrient-rich foods are familiar and easy to find, so healthy eating doesn’t have to be difficult, stressful, or negative. Visit www.3aday.org for more information, including science-based resources, recipes, meal ideas and a supermarket shopping list to help your patients build and enjoy a nutrient-rich lifestyle.



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