

VITAL SIGNS



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MEDICAL SOCIETY

Every physician matters,
each patient counts.



Questions about marijuana and medicine? See page 4.

VOLUME 22, ISSUE 9, NOVEMBER 2017

Practice Growing Pains: Coaching through Conflict

BY SARAH RUTH BATES, MBE

In a health care landscape characterized by evolving practice models, shifting regulations and reimbursements, and uncertain outcomes, what gives? Sometimes, professional harmony. “There’s a limit to how far you can push the workforce, and we’re seeing it: one sign is increased interpersonal conflict on the team level,” says Diana Dill, EdD, a consulting psychologist who works with physicians to address the strains and stressors of medical practice.

Any significant change in how health care is delivered and managed comes with a risk of generating or amplifying professional tensions. “After a practice merger, the old institution is no longer there. And the way the institution functioned is also no longer there,” says Cathy Lanteri, MD, a physician development coach. In this new environment, it is even more pressing for interpersonal conflicts to be better understood, resolved, or prevented.

Vital Signs spoke with three coaches about professional tensions related to health care redesign and practice evolution. The fictional scenarios below are based on themes that recur in physician coaching. These and similar issues are addressed in *Managing Workplace Conflict: Improving Leadership and Personal Effectiveness*, a two-day workshop offered by Physician Health Services at the MMS twice every 18 months.

1 Financial pressures generating interpersonal conflicts: power blocs within a practice

From Diana Dill, EdD; consultant and coach; founder, *Working Together for Health*; faculty, *Managing Workplace Conflict*.

SCENARIO

A physician is in a pediatric practice that’s losing money. To stabilize earnings, the practice required clinicians to work longer hours under increased productivity pressure. The practice also reduced clinician salaries. These changes exacerbated pre-existing divides between two power blocs. Each perceived the other as

having unfair advantages.

WHAT’S GOING ON

This situation is really a result of financial problems within the organization, but they’re felt on the team level, in face-to-face relationships every day. People feel hurt, put down, devalued. The two groups could not work together to solve their organizational problems.

REPAIR THE DAMAGE

Once a group has been in conflict for a while, there is usually a need for repair work. I draw from two main sources:

- The “Getting to Yes” model is based on a bestselling book (*Getting to Yes: Negotiating Agreement Without Giving In*, by Roger Fisher, William Ury, and Bruce Patton; Penguin, 1991) that summarizes the findings of the Harvard Negotiation Project, a conflict resolution initiative. In that model, a facilitator brings the conflicting parties together. Participants or groups have the opportunity to outline their position and what they’d like to see happen while the others listen. Look for the overlap; it’s rare that two groups are completely at odds. Once you know where their interests align, there’s a brainstorming process, which tends to make people more flexible. The two groups evaluate potential solutions together.

- Google’s research on group dynamics found that two factors predict successful group performance: first, people participate equally, and second, people are tuned in and sensitive to each other. When we think about repairing a group we try to put them on that footing.

2 Becoming the leader of a larger practice: making the loyalty shift

From Cathy Lanteri, MD, FAPA; certified Physician Development Coach; founder, Lanteri Coaching and Communication.

SCENARIO

One newly appointed medical director saw her new job as looking out for the needs of her fellow physicians, which she’d done over many years. In her previous role,

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State Hammers Out Details of Legal Marijuana Implementation

BY ROBYN ALIE, MANAGER, MMS HEALTH POLICY AND PUBLIC HEALTH

Recreational marijuana is now legal in Massachusetts, and retail sales are due to start on July 1, 2018. The state has been working to address the issues raised by legalization — among them, regulating production and sales, protecting and educating the public, and determining what implementation might cost and how to pay for it.

In January, legislators filed dozens of bills addressing these concerns, and a Joint Committee of the Legislature held hearings across the state. The MMS testified for strong public health protections, oversight, and funding for research, education, and substance use prevention and treatment programs. In July, the legislature passed a 44-page law, which was signed by Governor Baker and codified as Chapter 55 of the Acts of 2017.

Chapter 55 pays considerable attention to the public health implications of legal recreational marijuana, which were almost entirely absent in the ballot initiative. In addition, it raises the tax on recreational marijuana to 20 percent (subject to annual review), which includes an optional 3 percent local tax. This tax remains one of the lowest in the country and is significantly lower than the state’s tax on cigarettes.

Funding for Prevention and Education

Part of the tax revenues will be directed to a newly created Marijuana Regulation Fund, with earmarks for public and behavioral health funding.

The law created an independent five-member Cannabis Control

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Photo by Josh Rosenfeld

Cathy Lanteri, MD, FAPA (left), and Diana Dill, EdD, respond to MMS members’ questions at the MMS Women’s Leadership Forum, September 2017.



Prescription for Burnout Prevention

As the medical community struggles to confront the growing scourge of physician burnout, it's easy to ask the broad questions: How are administrative burdens contributing? What systemic change is needed? What can the MMS do to help?

But let's not forget the importance of the individual's own contribution to burnout prevention as well. How can you take steps to promote your own wellness?

After four decades in medicine, I have come to firmly believe that in order to maintain our own health, physicians must make sure we have a path to step away from the work for a moment and engage in something recreational — be it relaxing, educational, and/or stimulating.

The army knows that crack troops cannot be kept on the front line continuously, without a break, or they become fatigued and much less effective. In a similar fashion, physicians — who spend our days and nights fighting another kind of battle — need to be rested, as well.

Whether it is joining a softball club, learning a new language, studying astronomy like MMS Past President Mario Motta, or (in my case) meeting new friends through ham radio communications or playing tennis, it is these activities that help keep us sharp when we return to the battle line.

This approach by itself is necessary though not sufficient. It will prolong physicians' abilities to continue to care effectively, with a positive outlook, for their patients.

For those of you who are ham radio operators, like Jim Gessner (K1YSO) and me (WM1V), look for us on 40 meters.

— Henry L. Dorkin, MD, FAAP

Group Visits: When Patients Become Part of the Care Team

BY ALANA COLE, MMS INTERN

Can the group visit improve care delivery for low-income mothers and their babies? A new Well Child program in Lawrence is seeking to answer that question and more. Does the group visit have benefits that aren't accessible through traditional provider-patient interactions? How does the group visit change the clinician's role?

Vital Signs talked with Joshua St. Louis, MD, MPH, a third-year family medicine resident who established the Group Well Child Visit Program at the Greater Lawrence Family Health Center (GLFHC). In April, the MMS and Alliance Charitable Foundation awarded a \$10,000 grant to help expand this initiative.

This GLFHC program follows children from birth to age one through seven group visits of two hours each. Their mothers are recruited from a prenatal group care program or referred by providers who believe they could benefit from additional support and education. The program is funded by the Foundation grant and the patients' insurance plans. At the Well Child visits, clinicians provide routine well-child care. Mothers are screened for postpartum depression, smoking, contraception, and folic acid supplementation, and have the opportunity to learn more about neonatal care and share personal challenges.

How does the group visit benefit this community?

Joshua St. Louis (JSL): There is a fair amount of data supporting the idea that patients from underrepresented minority backgrounds have better outcomes when they receive care in group settings than in a one-on-one setting. It's more time with the doctor and more time for education. Patients are more willing to ask questions. Through the first year of parenting,

social support is really important. Everybody in the group becomes friends. The group empowers them to take control of their health, their baby's health, and their health care.

How does the group dynamic change the clinical conversation?

JSL: In one group, the women told us that it is fairly common in the Dominican Republic for a woman who has had babies only by C-section to be told, "You're not a real mother because you didn't suffer for your baby." This was weighing really heavy on the mothers' minds. These sorts of revelations happen every day in group, in a way that they do not happen in clinic.

What advice do you have for physicians new to the group visit model?

JSL: Facilitate! Turn everything into a question. If the patients wanted a class, they would attend a class. This program is different. In these groups, patients have a lot of great advice to offer each other. So, listen, let patients talk, and just sit back and be delighted by how much your patients know. Learning to facilitate groups allows you to be a better doctor all the time. You learn to sit and listen to your patient.

What advice do you have for other residents about starting programs?

JSL: You have to be willing to do it yourself, especially in a community health center. You often end up finding that no one says, "No, you can't do something"; they say, "Sure that sounds great, you're going to have to do it."



Photo courtesy of GLFHC
Joshua St. Louis, MD, MPH, with mothers and babies of the Group Well Child Visit Program.

Further Information

The GLFHC Group Well Child Visit program is in its first full year following a 2016 pilot. A 2010 study in *Family Medicine*, which evaluated a similar program, found that for parents the group well-child care model can promote "mutual support, shared learning, parental involvement, and more time with providers."

A study of a pilot Centering Parenting program, on which the GLFHC program is based, suggested its biggest benefit for residents was the opportunity to observe babies' development simultaneously and longitudinally (*The Permanente Journal*, 2011).

Additional information on group visits: *Putting Group Visits into Practice in the Patient Centered Medical Home* (MGH, 2014) goo.gl/V5fa2T

Apply for a Community Action Grant

The MMS and Alliance Charitable Foundation provides grants to nonprofit organizations and physician-led volunteer initiatives supporting community health around the Commonwealth. The deadline for applications is January 15, 2018. For more information, visit www.mmsfoundation.org.

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Disparate Specialties, Common Ground: Engaging Physicians in Care Redesign

BY LUCY BERRINGTON, MS

Engaging physicians in the transition to value-based health care calls for approaches that vary by specialty and practice setting, yet unite clinicians around shared goals, say leaders in health care redesign.

This is a key message of the Fourth Annual PPRC Talks: *Crucial Conversations in an Era of Transition*, a new online education program from the Physician Practice Resource Center at the MMS that explores strategies for empowering physicians as health care reform plays out. When physicians are facing unprecedented demands and vulnerability to burnout, and their roles in health care delivery vary so widely, it can be challenging to become involved in improving the broader patient experience and the coordination of care. This two-hour conversation lays out approaches that work.

Primary and Specialty Care Physicians

Improving population health usually begins with primary care practitioners, says Adam Licurse, MD, MHS, associate medical director at Brigham and Women's Physician Organization and at Partners Center for Population Health. "Primary care has been working on a lot of the building blocks for a while: organizing around teams, incorporating data, and bringing in additional resources to do this, such as nonphysician providers and other staff."

Engaging specialty providers in the transition to value-based care makes for a far more varied and complicated picture. This picture acknowledges differences between primary care and specialty care across multiple spheres, including patient populations, medical and technical challenges, and varying payment models, as well as that infrastructural readiness for system improvement. Provider-patient relationships and care goals may also be inherently different. Many specialties do not involve long-term relationships with patients, for example, and

may not have oriented toward lower-cost, community-based treatment approaches.

Acute care physicians may be especially removed from the process of system change, Dr. Licurse says. "When you're taking care of sick inpatients, some who just had heart attacks and some who have had severe pneumonias, and you're making critical decisions about their care minute to minute, it's often hard to find the time and the bandwidth to step back and think about care redesign or population health, though certainly that is what many organizations are trying to do."

For Some Specialties, This Comes Easier

The solutions do not lie in a single process or model. "Some specialties lend themselves more easily to this evolution to population health," says Sarika Aggarwal, MD, MHCM, chief medical officer at Beth Israel Deaconess Care Organization (BIDCO), an ACO incorporating eight hospitals and eight large physician groups.

"The risk-based payment models require primary care and specialists to work on population health solutions across the care continuum," says Dr. Aggarwal. "This redesign process is easier in specialties such as gynecology, ophthalmology, and endocrinology, where the primary care and specialty can collaborate on improving access, communication, and quality of care, with the primary carer still the MVP in that relationship."

Align Around Shared Goals

Engaging physicians requires clear potential benefits. "If you design the program you're asking them to engage with so it's really good for them and their patients, then you don't need to engage them per se — they will just want to do it," says Dr. Licurse. Before introducing change, ask whether it helps providers do their jobs.

Engagement also requires a shared purpose and value proposition, especially when it seeks to involve both hospital-based and outpatient-based providers. "At BIDCO, with its diverse



Photos by Josh Rosenfeld
Sarika Aggarwal, MD, MHCM (left), and Adam Licurse, MD, MSH (right).

communities of academic and community institutions, as well as employed and independent physician groups, we spent a lot of time to find a unifying purpose," says Dr. Aggarwal. "Improving care retention is now a key BIDCO goal which has brought all our communities together."

Improving the quality of care is another shared value, as Dr. Licurse, a primary care provider, found in his own practice. When analyzing patients' unmet care needs, bringing in consultants and additional staff worked only up to a point. "Our ambulatory quality teams realized that you need to bring providers into that work in the right way. The first time someone said to me, 'You've got to spend 10 minutes and go through this list,' it was not something I was necessarily excited to do. But the minute I started doing it, I realized that this is better care; I will feel better about my job at the end of the day. I hadn't seen these patients in a year — they really should be back in my office. Once you get over the difficulty of finding time, and see the gaps, you realize these solutions actually improve your care."

Let Go of Top Down

Engaging physicians calls for flexibility on the part of administrators too. Increasingly, they may be disseminating rather than sourcing ideas. "Most of our best practices actually don't come from us. Our providers and institutions are all creating and innovating, and we are sharing these ideas with our network," says Dr. Aggarwal.

Respecting the autonomy of providers is critical, she says. "We need to allow them the mastery of their own domain by giving them

resources and tools, at the same time as clear achievable goals and feedback."

At Brigham and Women's Hospital, lessons from venture capital are being applied to health care redesign. The Brigham Care Redesign Incubator and Startup Program (BCRISP) encourages clinicians to identify problems and potential solutions, and provides training and startup funding to facilitate that.

The collaborative process can be as simple, however, as reframing the conversation. "If you say to a group of specialists, 'Look, here are some data. You guys are all prescribing expensive medications at different rates. What are you going to do about it?,' people get defensive. There's always a good and defensible reason why the variation exists," says Dr. Licurse. "But you can flip that and say, 'We want to work with you to deliver better care. You tell us how you want to measure this. We'll agree on the finish line but you can run the race however you want.' Being more collaborative with data is something we're all interested in."

The Fourth Annual PPRC Talks: *Crucial Conversations in an Era of Transition* webinar is available free to MMS members at www.massmed.org/pprctalks2017.

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Marijuana Implementation

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Source: Prof. Dr. Otto Wilhelm Thomé Flora von Deutschland, Österreich und der Schweiz 1885

Commission (CCC), which will oversee all aspects of both recreational and medical marijuana.

The CCC — appointed by the governor, attorney general, and treasurer — will be responsible for developing regulations relating to product placement, marketing, and advertising; testing protocols; ensuring industry energy and environmental standards; and driver safety.

A 25-member Cannabis Advisory Board will advise the CCC. It is required to include at least one expert in toxicology or lab sciences, one expert in substance use disorder prevention and treatment, and a subcommittee on public health.

The CCC will also develop a research agenda so that the social, economic, and public health consequences of legalization are studied and reported. UMass has already begun baseline studies of use rates, motor vehicle fatalities, and the relationship between recreational marijuana use and prescriptions and other substance use.

A special commission of 13 members, including a representative from the MMS, will study the capacity of law enforcement to test for and prevent impaired driving. In September, the state's Supreme Judicial Court ruled to limit how alcohol field sobriety tests may be used to prosecute drivers.

Local and Federal Bans in Place

Meanwhile, more than 100 of the state's 351 municipalities have voted to ban local retail sales. Both recreational and medical marijuana remain federally illegal. There have been concerns that the current US attorney general may seek to prosecute marijuana businesses that are operating legally under state laws but in violation of federal laws.

Questions About Marijuana? MMS Collaboration Helps Providers Find Answers

BY TOM FLANAGAN AND LUCY BERRINGTON

“Can marijuana reduce my pain?” “Is it true this could relieve my IBS?” “How should I take it? What exactly should I take?” “I’m using marijuana recreationally — could it affect my treatment?”

In states where medical marijuana has been legalized — like Massachusetts — physicians and other health care providers may struggle to answer patients’ questions. And with recreational pot shops expected to open in the Commonwealth next year, those questions may become broader in scope and more frequent. Physicians may be wary of the disconnect between federal and state marijuana laws, and of marijuana’s uncertain effects on health and development. They may be concerned about the risk of prescribing a contraindicated treatment to a patient taking medical marijuana, and the implications of patients self-medicating with the recreational drug.

The Comprehensive Cannabis Curriculum, available from the MMS, is designed to give physicians and other providers a robust training on the medical, legal, and social issues relating to marijuana use. “The course addresses a huge knowledge deficit clinicians have regarding risks

and benefits of marijuana and other cannabinoids. This is just what doctors need to be able to have constructive conversations with their patients,” says Dr. Alan Ehrlich, assistant clinical professor in family medicine at UMass Worcester and deputy editor at DynaMed, who reviewed the program.

“I think most physicians want to understand medical marijuana in terms of those conditions for which there is evidence (preferably good) of efficacy, and those for which the evidence is weak or merely placebo,” says Kathryn A. Hughes, MD, acute care surgeon at Falmouth Hospital. “We also want to know if there is any dosing information, and the mechanics of certification and dispensing.”

The curriculum is a collaboration between the Massachusetts Medical Society and Stephen Corn, MD, and Meredith Fisher-Corn, MD, of the medical education website TheAnswerPage.com. “Whether or not physicians have any intention of recommending medical cannabis for patient care, they now all need to be well educated on the endocannabinoid system and medical cannabis, because their patients will be seeking their expert advice and guidance for this legal medication,” says Dr. Corn.

In 17 modules, the program covers the endocannabinoid system, medical cannabis dosing and contraindications, and metabolism and drug interactions. Studies addressing the physiologic, cognitive, and mental health effects of cannabis are reviewed in detail, as is the medical use of cannabis for 10 disease states: ALS, cancer, epilepsy, HIV/AIDS, Huntington’s Disease, IBS, multiple sclerosis and spasticity, neuropathic pain, and Parkinson’s Disease.

“The chapters have been written by leading experts and the presentation is very balanced with an emphasis on the best available evidence,” says Dr. Ehrlich. The course was also reviewed by the MMS Committee on Sponsored Programs. The curriculum does not represent a recommendation by the MMS for or against the use of cannabinoid medications, says Dr. Henry Dorkin, president of the Society.

TheAnswerPage has been offering peer-reviewed medical educational content since 1998, focusing on medical cannabis, pain, and opioids. Drs. Corn and Fisher-Corn, received the 2017 Special Award for Major Contributions to the Reintroduction of Cannabis as Medicine from the International Association for Cannabinoid Medicines.

Peer Review: Two Physicians Check Out the New Cannabis Curriculum



Matthew Katz, MD

MATTHEW KATZ, MD, medical director of radiation oncology at the Cancer Center, Lowell General Hospital; chair of the MMS Committee on Communications.

“I did six modules. Modules 2, 4, and 5 were the best for an overview. General guidance and awareness about possible effects

of cannabis exposure are helpful for clinical practice, even without certification. The course does a good job of covering the available medical literature. Learning about the history of cannabis research was also helpful to better understand what we know and don’t know about cannabinoids. The modules are an excellent way to meet state requirements for risk management CME credits.”



Ammu Susheela, MD

AMMU SUSHEELA, MD, research fellow in anesthesia, at Beth Israel Deaconess Medical Center.

“I wanted to know: Could medical cannabis benefit people who are addicted in any way? Do habitual cannabis users need a higher dosage to get the therapeutic effect? The most important information

for me was that medical cannabis can be very beneficial for patients with Huntington’s. It also covered the mechanism of the effect. This curriculum does give a different perspective; it opened up a lot of evidence for me on how medical marijuana could be useful, though I still feel cautious. The curriculum did not distinguish between people who were addicted and not addicted; the research is limited.”

Bending the Cost Curve: Next Up on Beacon Hill

BY BRENDAN ABEL, JD, MMS LEGISLATIVE COUNSEL

Legislators and regulators across the state have again honed in on health care cost containment as a major priority for legislative action. The state Senate has hosted a series of listening sessions in anticipation of a comprehensive proposal to address health care costs, and the governor and the Speaker of the House have acknowledged the importance of the issue. What will such a bill contain? And what does the underlying data say about cost growth in Massachusetts, especially as it pertains to physician costs?

Health Care Costs in Massachusetts

The state of health care costs is really in the eye of the beholder. Many, for example, point to the fact that Massachusetts is, year after year, one of the most expensive states in health care spending, coming in at nearly 30 percent higher than the national average per capita. MassHealth, the state Medicaid program, takes up nearly 40 percent of the

state budget. Medical cost sharing for families in Massachusetts continues to climb faster than average income does.

But that's not the full story. From 2015 to 2016, total health care expenditures increased at just 2.8 percent, well below the health care cost benchmark set by the state's Health Policy Commission.

Between 2009 and 2014 the state's annual rate of health care spending growth was the fourth lowest in the country, at 2.3 percent. Higher net per capita spending reflects the higher cost of living and wages in Massachusetts, many point out.

This leads to the vexing policy question: Should the promising trends in the rate of growth support a hands-off approach that allows more time for existing policies to take hold, or do the overall net statistics warrant further policy intervention?

And here is yet another difficult question: If further legislation is the solution, what should that look like?

Policy Options

From the Medical Society's perspective, the data on strong trends in the rate of growth should at least temper the level of intervention and make the case for targeted policies to address specific areas of cost growth. Insightful data has been published by various state agencies that can help identify areas to target.

Physician costs in Massachusetts are rising slowly. Total health care expenditures for physicians rose 1.7 percent in 2016 and accounted for just 7.7 percent of the total health care expenditure growth in Massachusetts. Pharmacy spending, in contrast, increased 6.4 percent in 2016 and accounted for 27.5 percent of the increase in health care expenditures over the same period.

The Medical Society believes that these and similar statistics should guide policymakers toward targeted policies that address specific drivers of cost, and to continue existing policies in

areas showing positive growth trends, such as physician spending.

The Medical Society has suggested policy proposals that will continue to help physicians provide the highest value care to patients. Promoting telemedicine, for example, can provide wrap-around communication with complex patients, yielding cost savings. Legislation improving medical decision-making for incapacitated patients could also help reduce lengthy delays in transfers to lower-cost settings.

These approaches contrast with early budget proposals this year that would cap rates of growth in physician reimbursement or cap certain segments of physicians' reimbursement to percentages of Medicare. The Medical Society argues vigorously that these approaches are not consistent with the underlying costs data.

The Society will continue to advocate for policies in the best interest of physicians, their patients, and the health care delivery system at large.

MMS Launches 2018 Anti-Tobacco Poster Contest

Look out for our Anti-Tobacco Poster Contest kits. These will be mailed by the MMS and the MMS Alliance in early November to pediatricians, family physicians, and elementary schools in Massachusetts. The contest is open to children in grades 1–6. Contestants create and submit original posters relevant to the theme for their grade category:

Grades 1–2:
Tobacco Is Bad for Your Body

Grades 3–4:
Tobacco Affects Other People

Grades 5–6:
Why I Won't Start Smoking
Posters will be judged on originality, creativity, and relevance to the

theme. Winners will be invited to a ceremony at the Massachusetts State House, where they will be awarded a \$50 gift certificate.

The contest deadline is February 23, 2018. For more information and for last year's winning posters, visit www.massmed.org/ATPC2018.

Tobacco Free Mass — Join Us in Celebrating a 25-Year Legacy of Success

The fifth annual awards breakfast and fundraiser of Tobacco Free Mass will be held on November 21, 7:15 a.m., at MMS Headquarters, Waltham. Tobacco Free Mass is a privately-funded coalition advocating for funding and policies that support tobacco prevention and cessation and reduced public exposure to secondhand smoke. The MMS was a founding member of the coalition, which is chaired by Lynda Young, MD, a past president of the Society.

The keynote speaker at the fundraiser will be John Auerbach, president and CEO of Trust for America's Health, a nonprofit that promotes sound public health policy and disease prevention. Harold Cox, associate dean for public health practice at Boston University School of Public Health, will serve as master of ceremonies. For more information and tickets, go to tobaccofreema.org.



Photo by Jill Cricones

Last year's winners gather at the State House with MMS Alliance President Sandra Delgado, MMS Committee on Student Health Sports Medicine Chair Michael Guidi, DO, and MMS President Henry Dorkin, MD, FAAP. Middle row (left to right): Lianna Morrison, Jessica Guo, Shreya Budakoti, Davin Taylor, and Shaelin Francis. Front row (left to right): Riley Mead, Shirley Montenegro, Anna Grace Goodman, Madison Rodick, Soumya Gupta, Olivia Daughenbaugh, and Amy Dewitt.

Growing Pains

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her focus was on patient care and working as a team. In her new role, she hadn't incorporated her responsibility to the institution, including its financial viability, regulatory compliance, and more.

WHAT'S GOING ON

The changing medical environment requires all physicians to make this transition to some extent, as physicians shift from being individual providers to members of larger care teams or institutions. This requires internalizing a broader identity. For leaders, this new identity includes making decisions that are in the institution's best interest.

RECOGNIZE THE SHIFT

The physician's new appointment required prioritizing the institution's goals and its success. Becoming aware of that was enough for her to see her responsibilities more broadly.

3 Becoming colleagues with former competitors: two practices merge

From Gail Gazelle, MD, FACP, FAAHPM; professional certified coach, assistant professor of medicine, Harvard Medical School.

SCENARIO

A physician is part of a newly consolidated group of cardiologists within Hospital X. Some of those cardiologists have always worked for Hospital X, but many worked for Hospitals Y and Z. Now they're strange bedfellows. It's not hard to imagine conflicts

that arise: physicians feel allegiances to the hospitals they used to work for, and they have to work with colleagues who used to be their competitors.

WHAT'S GOING ON

If we want to maintain and build goodwill — for example, when a former competitor becomes a partner and teammate — we need to stay focused on that fact that we're working with another human being who wants similar things to us. That includes job security, fulfillment in their work, a sense of belonging, and the ability to see patients without a huge amount of hassle.

FOCUS ON A COMMON GOAL

The key here is to maintain the priority of excellence in patient care, and avoid focusing on individual interests, such as who gets the desirable office or priority in the call schedule. If you can focus more on the overall goals of patient care, and functioning collaboratively in a competitive marketplace, you'll be more likely to get a



Photo by Ana Matei-Zsok
Gail Gazelle, MD, FACP, FAAHPM, coaches a client.

buy-in from people to make changes that require growth and shifts.

START WITH THE END IN MIND

This approach helps frame the focus on the organization's mission, and is described in Dr. Stephen Covey's bestseller, *The Seven Habits of Highly Effective People* (Free Press, 2004). Physicians facing a practice merger tend to start in a competitive mindset: Who's going to get higher-reimbursing cases? Who's going to get the easy cases? If you start with the end in mind, i.e., a vision for how you can all function together, it's a lot easier to get where you want and need to go. That vista from the vantage point of the end goal is often much clearer.

Managing Workplace Conflict: Improving Leadership and Personal Effectiveness

MARCH 22–23, 2018, MMS HEADQUARTERS, WALTHAM

Registration will open in mid-January at www.massmed.org. Approved for AMA PRA Category 1 Credits™, this activity meets the criteria for the Massachusetts Board of Registration in Medicine for risk management study. Jointly provided by the Massachusetts Medical Society and Physician Health Services, Inc.

Can't Make the Interim Meeting? Your Online Testimony Helps Shape MMS Policy

BY KATE CONNORS

At last spring's MMS Annual Meeting, delegate Kathryn A. Hughes, MD, wanted to provide testimony on a resolution that she had introduced. As the chair of a different reference committee, however, she was concerned that she would not get an opportunity to participate in the hearing on her own resolution.

Her solution? Submitting testimony in advance through the MMS website.

Dr. Hughes ended up being able to testify in person. She focused her speech on a few salient points, while her online testimony provided a thorough perspective on her resolution.

The online testimony function has been available to all members — not just delegates — since 2010. It's a convenient way for members of the Medical Society to have a direct voice to the organization's policymaking arm.

Online testimony is valuable to committee members as they review and amend potential policies for debate by the full House. "It really does enhance the verbal testimony that the reference committee will hear in person," says Dr. Hughes.

Dr. Hughes does not discount the value of verbal testimony from MMS members who are able to be there in person: "There is the connection and emotional impact of having commenters show up."

But for many MMS members, sharing thoughts online in our secure forum can be an important way to have a voice in policy decisions that impact patients and shape today's practice of medicine.

Members will be able to review resolutions and submit online testimony for the 2017 Interim Meeting beginning the evening of November 7, 2017. Visit www.massmed.org/hodcommunity.

2017 Interim Meeting

of the MMS House of Delegates

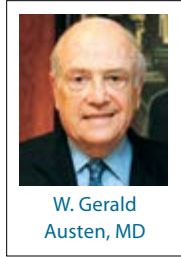
Friday and Saturday, December 1–2, 2017

MMS Headquarters and the Westin Hotel, Waltham

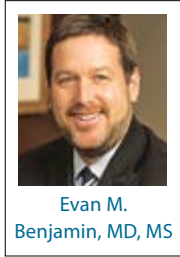


- The *Delegates' Handbook* posts online **Tuesday, November 7** at www.massmed.org/117handbook.
- Pre-registration closes **Monday, November 27**, at noon; register today at www.massmed.org/interim2017/register.
- The MMS hotel deadline has passed but rooms may still be available. Please visit www.massmed.org/IM17reservations or contact Laura Bombrun at lbombrun@mms.org or (781) 434-7007.
- Register for these exciting Interim Meeting events: the Town Hall Forum with the presidential officers, the Annual Oration, the biannual Ethics Forum, and the 12th Annual Research Poster Symposium, which offers a venue for residents, fellows, and medical students to display their original research.

MMS Member News and Notes



W. Gerald Austen, MD



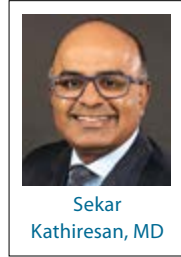
Evan M. Benjamin, MD, MS



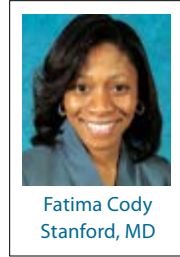
Michele David, MD



Jennifer R. Gatchel, MD, PhD



Sekar Kathiresan, MD



Fatima Cody Stanford, MD

W. GERALD AUSTEN, MD (Harvard Medical School, 1955; residency: Massachusetts General Hospital), has been awarded the 2016 National Physician of the Year, a lifetime achievement award from Castle Connelly Medical Ltd. Dr. Austen is chair of the MGH Chiefs Counsel and Surgeon-in-Chief, Emeritus, at MGH, and Edward D. Churchill Distinguished Professor of Surgery at Harvard Medical School.

(Photo: Knight Foundation.)

EVAN M. BENJAMIN, MD, MS (Case Western Reserve University School of Medicine, 1987; residency: Yale New Haven Hospital; Masters in Healthcare Delivery: Dartmouth), has been appointed chief medical officer at Ariadne Labs, a joint center of Brigham and Women's Hospital and the Harvard T.H. Chan School of Public Health. Previously, Dr. Benjamin was senior vice president for quality and population health at Baystate Health, where

he established a nationally recognized Quality Improvement program, the Center for Quality of Care Research, and cofounded TechSpring, a health IT innovation hub. "With Evan's arrival, Ariadne gains a national leader in quality improvement and implementation science and a seasoned health care executive," said Dr. Atul Gawande, executive director of Ariadne Labs.

MICHELE DAVID, MD (University of Chicago Pritzker School of Medicine, 1988; residency: Columbia University Medical Center), has been appointed chief of clinical quality and safety at MIT Medical. Dr. David, a primary care practitioner, serves on the Public Health Council, the policy arm of the Massachusetts DPH. Her teaching, research, and advocacy focus on addressing health disparities and promoting culturally competent best practices. Previously, Dr. David was associate professor of medicine at the BU School of Medicine.

JENNIFER R. GATCHEL, MD, PHD (Baylor College of Medicine, 2009; residency: MGH/McLean Hospital; fellowship: Partners HealthCare Geriatric Psychiatry), has received the 2017 Outstanding Emerging Researcher Award from the BrightFocus Foundation for her research on changes in the brain in late life depression and Alzheimer's disease. Dr. Gatchel is a psychiatrist at MGH and instructor in psychiatry at HMS. She was previously the recipient of the 2016 American Association for Geriatric Psychiatry (AAGP) Member-in-Training Research Award.

SEKAR KATHIRESAN, MD (Harvard Medical School, 1997; residency and cardiology fellowship: MGH), has received a Distinguished Scientist Award from the American Heart Association (AHA). Dr. Kathiresan is director of the Center for Genomic Medicine at MGH, director of the Cardiovascular Disease Initiative at the Broad Institute, and

associate professor of Medicine at Harvard Medical School. This award recognizes his research into the genetic basis for heart attacks, including developing a genetic test aimed at heart attack prevention. It is the highest honor that AHA bestows on a science volunteer.

FATIMA CODY STANFORD, MD, has been honored by Emory University in its inaugural listing of 40 Under Forty influential alumni. Dr. Stanford is an obesity medicine physician at the MGH Weight Center and an instructor in medicine and pediatrics at Harvard Medical School. She has received the MMS 2017 Women's Health Award, the Gold Congressional Award, and the Harvard Medical School Diversity Award. Dr. Stanford was honored for her pioneering work in obesity medicine, which bridges policy and research.

ACROSS THE COMMONWEALTH

District News and Events

NORTHEAST REGION

- Charles River — Delegate's Meeting-Resolution Review.** Tues., Nov. 14, 6:30 p.m. MMS Headquarters, Waltham.
- Essex North/Essex South — Delegate's Meeting-Resolution Review.** Tues., Nov. 28, 6:00 p.m. Joseph's Trattoria, Haverhill.
- Middlesex — Delegate's Meeting-Resolution Review.** Wed., Nov. 29, 6:30 p.m. MMS Headquarters, Waltham.
- Middlesex Central — Delegate's Meeting-Resolution Review.** Thurs., Nov. 16, 7:45 a.m. Emerson Hospital, Concord. Holiday Party. Sun., Dec. 3, 4:00 p.m. Concord Country Club, Concord.
- Middlesex North — Delegate's Teleconference-Resolution Review.** Tues., Nov. 28, 7:30 a.m.

- Middlesex West — Delegate's Meeting-Resolution Review.** Mon., Nov. 27, 6:00 p.m. MacPherson Hall, Framingham Union Hospital, Framingham.
 - Norfolk — Delegate's Meeting-Resolution Review.** Mon., Nov. 27, 6:00 p.m. MMS Headquarters, Waltham.
 - Suffolk — Delegate's Meeting-Resolution Review.** Thurs., Nov. 16, 6:00 p.m. East Garden Room, MGH, Boston.
- Northeast Regional Office: (800) 944-5562 or mjussaume@mms.org or lhoward@mms.org.

SOUTHEAST REGION

- Norfolk South — 19th Annual Smoke Out.** Mon., Nov. 13-Fri., Nov. 17. Elementary and middle schools on the South Shore.
- Holiday Event.** Sun., Dec. 10, noon-4:00 p.m. Trattoria San Pietro, Norwell.

- Barnstable, Bristol North, Bristol South, Norfolk South, Plymouth — Southeast Regional Caucus.** Tues., Nov. 21, 6:00 p.m. LeBaron Hills Country Club, Lakeville.
- Southeast Regional Office: (800) 322-3301 or skozlowski@mms.org.

WEST CENTRAL REGION

- Hampden — Executive Board Meeting.** 6:00 p.m. Caucus Meeting. 6:30 p.m. Tues., Nov. 28, 6:00. Hampden District Office, Elm Street, W. Springfield. Please call (413) 736-0661 for more information.
- Worcester — Fall District Meeting.** Wed., Nov. 1, 5:30 p.m. Beechwood Hotel, Worcester. The meeting includes the Dr. A. Jane Fitzpatrick Community Service Award, the WDMS Career Achievement Award, and Scholarship Award

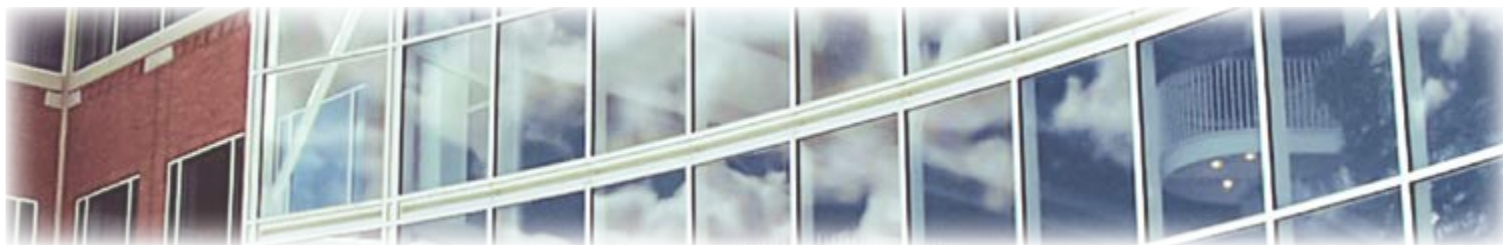
Presentations. For more information, call WDMS at (508) 753-1579.

- Worcester North — Executive Committee Meeting.** Wed., Nov. 15, 5:00 p.m. Fay Club, Fitchburg.
- Fall District Meeting.** Thurs., Nov. 16, 6:00 p.m. Fay Club, Fitchburg. Speaker: Joel Popkin, MD. Topic: Symphony of the Brain.

West Central Regional Office: (800) 522-3112 or csalas@mms.org.

Statewide News and Events

- Arts, History, Humanism, and Culture Member Interest Network — Executive Committee Meeting.** Wed., Nov. 8, 6:00 p.m. MMS Headquarters, Waltham.
- Contribute statewide news: (800) 522-3112 or csalas@mms.org.



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VITALSIGNS

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MMS AND JOINTLY PROVIDED CME ACTIVITIES

LIVE CME ACTIVITIES

Unless otherwise noted, event location is MMS Headquarters, Waltham. Visit www.massmed.org/cme/events.

2017 Annual Orator: Traumatic Brain Injury, Concussion, and American Football
Friday, December 1, 2017

Ethics Forum: CRISPR and the Ethics of Germline Manipulation
Friday, December 1, 2017

ONLINE RISK MANAGEMENT CME ACTIVITIES

NEW Legal Advisor: Treating Hearing Impaired Patients

NEW Restoring the Well Being to the Medical Profession

Comprehensive Cannabis Curriculum
(1–16 Modules)

- Module 1 — Endocannabinoid System and Phytocannabinoids
- Module 2 — Guidance on the Recommendation of Medical Cannabis
- Module 3 — Cannabis Products, Modes of Administration, Dosing Considerations & Contraindications
- Module 4 — Cannabis — Physiologic and Cognitive Effects
- Module 5 — Cannabis Use and Mental Health Effects
- Module 6 — Cannabinoid Hyperemesis Syndrome

- Module 7 — The History of Medical Cannabis
- Module 8 — Medical Use of Cannabis and Cannabinoids in Amyotrophic Lateral Sclerosis
- Module 9 — Medical Use of Cannabis and Cannabinoids in Cancer
- Module 10 — Medical Use of Cannabis and Cannabinoids in Epilepsy
- Module 11 — Medical Use of Cannabis and Cannabinoids in HIV/AIDS
- Module 12 — Medical Use of Cannabis and Cannabinoids in Huntington's Disease
- Module 13 — Medical Use of Cannabis and Cannabinoids in Inflammatory Bowel Disease
- Module 14 — Medical Use of Cannabis and Cannabinoids in Multiple Sclerosis (and Spasticity)
- Module 15 — Medical Use of Cannabis and Cannabinoids in Neuropathic Pain
- Module 16 — Medical Use of Cannabis and Cannabinoids in Parkinson's Disease

FOR ALL OTHER ONLINE CME ACTIVITIES, visit www.massmed.org/cme.

CME CREDIT: These activities have been approved for *AMA PRA Category 1 Credit™*.

FOR ADDITIONAL INFORMATION AND REGISTRATION DETAILS, GO TO WWW.MASSMED.ORG/CMECENTER, OR CALL (800) 843-6356.

Restoring Well-Being to the Medical Profession

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