The Evolution of Global Health
What Physicians Should — and Shouldn’t — Expect from Projects Abroad

BY LUCY BERRINGTON, MS, VITAL SIGNS EDITOR, AND KATE CONNORS, MA

As more physicians seek out medical experiences in the developing world, efforts are underway to build global health into physicians’ career paths and raise standards in the systems and organizations that support health projects abroad. These trends reflect a shifting understanding of global health. Increasingly, global health is recognized as an essential component of public health, benefiting everyone, rather than a philanthropic add-on. This comes with an urgency around learning from past mistakes, including efforts that inadvertently burdened the countries and communities they were intended to help.

Doctors in the US seek out global health experiences for various reasons: to support under-resourced communities abroad, experience medicine in a new way, gain relevant insights and skills, or take a break from elements of US practice. Vital Signs talked with physicians connected with the Massachusetts General Hospital (MGH) Center for Global Health about what clinicians can expect to bring to, and get from, their global health experiences.

Professionalization of Global Health
Global health experience for US physicians in training has increased in recent decades, according to the American Association of Medical Colleges. In 1984, six percent of graduates reported a global health experience during medical school; recently the figure surpassed 30 percent. Similarly, growing globalization has led to an increase in physicians engaging in international medical volunteerism — short-term placements in low-resource settings that allow doctors to maintain their practices in the US.

That trend is part of a gradual “professionalization” of global health. “Maybe 10 years ago people used to think of global health as a sideline issue. But there are people who are trying to professionalize it and make it much more part of their career,” says Adeline A. Boatin, MD, MPH, an OB/GYN at MGH who has a longstanding collaboration with a hospital in Uganda.

Past mistakes in global health are focusing attention on how to maximize the benefits across the board. The pitfalls have been striking in some disaster response scenarios, says Paul D. Biddinger, MD, chief of the division of emergency preparedness at MGH, who helped direct recent domestic post-hurricane relief efforts in Texas and Puerto Rico, and also has global disaster experience. “Historically there have been challenges with ‘disaster tourism,’ people who have a desire to help but also to see other parts of the world and to get a life experience in a difficult setting.”

In global health, good intent is not enough. Volunteers may end up consuming scarce resources, undermining local care systems, or performing...
Looking toward the end of my term as president of the Medical Society, it feels appropriate that I’m writing this last message in the pages of an issue about global health.

If it’s true that “all politics is local,” then is it also true that “all health is global?”

In an era of globalization, we are only one plane ride away from the next pandemic. That’s a terrifying thought. However, that’s not the whole story.

Today, we can pool worldwide data to better understand disease and to improve treatment. We can learn from other systems about health care delivery that works. We can leverage innovative solutions to the opioid crisis that have been proven successful elsewhere and use that information to save lives at home.

In the past year, specialists in Massachusetts were able to use HIPAA-compliant voice recognition programs to help doctors on the ground in Puerto Rico after the devastating hurricane. Some of our members also traveled to disaster areas to bring empathetic care to survivors — right when and where they needed it most.

But is all health care global? When we’re sitting in the exam room with a scared patient, that’s about as local as it gets.

Our Commonwealth is an interesting mix of local and global. We are a hub of groundbreaking research and medical innovation — but we are also a state of small towns and community physicians. We all have our equally important roles to play in health care. I like to think that that’s part of what makes us great.

For more on epidemics, though, you will have to join us at the Annual Education program, as well as the Shattuck Lecture being given by Mr. Bill Gates. See you there!

—I. L. Dorkin, MD

“Colorful” Physician Leader Helped Colleagues Take Creative Breaks from Medicine

BY LUCY BERRINGTON, MS

A highly regarded Worcester surgeon who had a vital role in uniting physicians around artistic interests and the natural world has retired from the MMS Member Interest Network.

Over 17 years, Edward L. Amaral, MD, was the founding chair and subsequent vice-chair of the Arts, History, Humanism, and Culture Member Interest Network (AHHC&C MIN, or MIN). The MIN brings together Massachusetts physicians for events relating to art, creative writing, astronomy, birding, gardening, medical history, music, photography, and — Dr. Amaral’s own area of artistry — stained glass.

“Ed’s art work is colorful, warm, bright, engaging. All these things you’d say about his stained glass could also be said about his personality and contribution to the Society,” says Robert W. Sorrenti, MD, medical director at UniCare, who took over from Dr. Amaral as chair of the AHHC&C MIN.

The Society created the MIN to broaden member engagement and add networking opportunities. “Physicians use these outlets to help achieve the right balance in their lives,” says Dr. Sorrenti. “In 2000, the Member Interest Network was a new entity with a mission to build opportunities for MMS members to express their nonmedical-related interests. Ed was the right person in the right place at the right time. He’s very collegial and affable. He was open to the participation of members and supportive of their ideas, and very attentive to individuals.”

Dr. Amaral’s stained glass work includes two pieces displayed at the MMS Headquarters in Waltham, and regular contributions to the art shows at MMS annual meetings — including a door panel that will be featured in this year’s Nancy N. Caron Annual Member Art Exhibit on April 26.

Dr. Amaral, age 82, joined the MMS in 1966 and served the organization in various capacities. In 1996, when Dr. Amaral became president of the Worcester District Medical Society (WDMS), he called for unity among physicians across practice affiliations, models, and payers, and for members’ participation in the medical community. He served as a WDMS delegate, a member of several WDMS and MMS committees, and (in 1993) as the annual WDMS orator.

When Dr. Amaral stepped down as district president, Joel Popkin, MD, wrote to him, “Your honest, caring, and straightforward approach is not only effective but truly refreshing. Thanks so much for the great work you have done.” Joyce Cariglia, executive director of the WDMS, worked with Dr. Amaral for 32 years. “He is a wonderful man, humorous, warm, and genteel. I can’t say enough about him.”

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EDITOR: Lucy Berrington
EDITORIAL STAFF: Charles Alagero, Office of General Counsel; Robyn Alle, Public Health; Lori DiChiaro, Government Relations; Yael Miller and Jillian Pedrotty, Managed Care; Stephen Phelan, Membership; Cathy Salas, West Central Regional Office; Deanna Biddy, Physician Health Services

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PRESIDENT: Henry L. Dorkin, MD
EXECUTIVE VICE PRESIDENT: Lois Dehls Cornell
DIRECTOR OF COMMUNICATIONS AND MEDIA_relations: Kate Connors

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misjudged interventions, says Hilarie H. Cranmer, MD, MPH, director of global disaster response at MGH. After the Haiti earthquake, Dr. Cranmer ran the largest field hospital there, confronting the challenges of ad hoc medical volunteerism. “More than 80 percent of responders were under 30 years old with little to no disaster experience. More than 40 percent of amputations were unnecessary,” she says. Some volunteers had health needs that required medical evacuation; others developed post-traumatic stress.

The news that Oxfam aid workers sexually exploited Haitian girls similarly highlights the need for personal and institutional accountability. “There are beliefs that the rules don’t apply in a disaster situation,” says Dr. Biddinger. “To treat it as the Wild West or a ‘practice area’ [for expanding scope] is unfair to those affected by the disaster and I don’t think that is ethically sound.” The World Health Organization (WHO), working with the Pan American Health Organization (PAHO) and other nongovernmental organizations (NGOs) and stakeholders, developed standards after Haiti for emergency medical teams (EMTs).

Forming Long-Term Relationships
Developing ongoing relationships between practitioners, institutions, and countries helps ensure the value of global health efforts for both sides. Dr. Boatin’s connection with the academic medical center in Mbarara, Uganda, is part of a long-term capacity-building partnership between that hospital and MGH; she is currently working with faculty and staff there to reduce maternal mortality and infection rates.

For the first two years of her involvement, Dr. Boatin spent about four months a year (not consecutively) in Mbarara, an arrangement she negotiated with MGH first as a global health fellow, then as an attending. In 2017, she made five two-week visits. “It’s much harder to get anything done in two weeks if you don’t already have an established relationship,” she says.

Supporting Not Displacing
A key to successful partnerships is collaboration, says Dr. Biddinger, who also serves on a federal disaster response team. “Emergency medical teams should be working in support of and under the direction of local health authorities, so they are supporting and adding to, but not replacing, the local health infrastructure.” Otherwise, local practitioners, clinics, and pharmacies can be implicitly discredited or displaced by visiting medics.

This is the same learning trajectory that saw public health practitioners move away from “top-down” interventions toward community-based, participatory models. Laura E. Riley, MD, vice chair of obstetrics at MGH, who works with Dr. Boatin in the Uganda program, says, “We needed not to be two women from Harvard coming in and telling them how to run their business.”

Setting Realistic Expectations
Dr. Cranmer, who chaired the NGO advisory board on EMTs for the PAHO, has pioneered screening and training systems designed to ensure MGH volunteers’ physical and psychological fitness and preparedness. “The willingness to help is very powerful and it is the mission of global disaster response at the Center for Global Health to help those who want to help others, and to get you back home to your family and your work at MGH,” says Dr. Cranmer. And maybe to other projects abroad: “I like to call disaster response the gateway drug to global health.”

The hospital provides logistical and infrastructural support (the teams must be 100 percent self-sufficient), and established relationships with the federal government, the WHO, other organizations, and teams from other Boston hospitals.

Physicians’ Added Value
Volunteer physicians unquestionably — and appropriately — benefit from their experiences abroad. “Most medical providers have a desire to help. We recognize that we have special skills that are often in short supply,” says Dr. Biddinger. “It’s the wrong thing to do this to go get experience — this should be about victims, not yourself — but that being said, you can’t help but get something out of it, you can’t help but grow and be changed.”

The contrast between practicing in resource-rich and resource-poor countries can serve as a powerful reminder of physicians’ reasons for going into medicine.

“There can be rejuvenation in going to a place that’s about raw clinical practice, where every patient you interact with really needs your care,” says Dr. Boatin.

Physicians are also especially valuable as educators. “Those residents are going to be the only doctor with that training in an entire region. It feels whatever you’re doing goes that much further,” says Dr. Boatin.

Physicians also report that global experiences can restore their faith in US practice, enhance their cultural competence, and help preserve basic clinical skills, such as physical diagnosis.

Finding a Global Career Path
Career paths in global health are emerging and vary by specialty, says Dr. Boatin, who co-authored a 2017 article exploring the opportunities for creating sustainable work models for academic OB/GYNS in global health work (Obstetrics & Gynecology). The avenues include grant-funded research projects, flexible hospitalist shift models, and global health fellowships.

For extended coverage, including how to help with a disaster response, see massmed.org/vitalsigns.

Financial Series

Does it stress you out thinking about securing your financial success?

You are not alone.

Nearly half of American doctors feel they’re behind in preparing for their financial future, according to the AMA Insurance Agency’s 2016 report on US physicians’ financial preparedness.

Most medical schools and training programs do not offer financial preparation courses. The Massachusetts Medical Society created this curriculum to help physicians, especially residents, understand the basics of compensation models, employment contracts, and negotiating terms.

massmed.org/financeseries

Keep your eyes open for future programs in this series.
Infection Interpol: Tracking Organisms to Massachusetts

By Robyn Alie, Manager, MMS Health Policy and Public Health

How is global disease tracked in the Commonwealth, and how does that affect patient care? Vital Signs asked Alfred DeMaria, MD, medical director of the Bureau of Infectious Disease and Laboratory Sciences in the Massachusetts Department of Public Health (MDPH) and the state epidemiologist, how outbreaks abroad become local.

VS How and why do emerging infections and outbreaks in other parts of the world affect Massachusetts?

DeMaria The most important factor is that more people are traveling. People from Massachusetts go to the developing world — as tourists, to work, to learn — and then they come back after being exposed to conditions that we need to pay attention to. People from all over the world come to Massachusetts as well.

For example, all the cases of measles we have dealt with have originated in people who’ve traveled from other parts of the world. There’s very little transmission of tuberculosis (TB) in Massachusetts. Close to 90 percent of cases of TB we diagnose in Massachusetts are in people who went elsewhere in the past — five to 50 years ago — who are now, for a variety of reasons, developing active disease. If we don’t do something about TB in the rest of the world we will never eliminate TB in Massachusetts.

VS What other diseases are you monitoring?

DeMaria Last year, there was an outbreak of yellow fever in Angola, and it spread to the Democratic Republic of the Congo. Fifty years ago, nobody from Massachusetts was likely to go there. Now we have to be aware of outbreaks that occur in the developing world as well as in the developed world.

It’s very important that we keep an eye on what’s going on not only with transmission but also with control efforts. Another good example is avian influenza in China. We’re monitoring the surveillance that the Chinese CDC is doing on human cases and bird cases, because they’ve been observing an increase. Now, is the level of concern such that we would warn every clinician in Massachusetts to be on the lookout? No. But it could conceivably get to that.

VS How does your surveillance affect clinical practices here?

DeMaria The MDPH gets a lot of calls from physicians in Massachusetts who are concerned about certain cases that have implications because someone has traveled. They say, “I have this patient with pneumonia who is not responding to therapy. They were traveling two weeks ago; should I be concerned?” And the answer is yes.

A special concern, though not big in volume, is people who seek health care elsewhere and could be exposed to organisms in health care facilities. In other parts of the world, people can just buy antibiotics over the counter, so the opportunity for organisms to become resistant is higher. The first cases we’ve seen in Massachusetts of the New Delhi strain of gram-negative organisms — which are resistant to multiple drugs, including the carbapenems — were in people coming from different parts of the world. They can be Massachusetts residents who went to India, for example, for surgery.

If you’re not aware of it, if you don’t recognize it, then there’s potential for spread within a facility. We work closely with our hospitals on infection control. If somebody goes from the hospital to a nursing home carrying one of these bugs, we have to make sure that the nursing home does what’s necessary.

Another example is Candida auris. This is a yeast that was not really identified in human infection until fairly recently, but has the potential for being resistant to the drugs that are used to treat yeast infections. It also has the potential to contaminate the environment, so somebody using the same room after a patient is discharged could conceivably be exposed. There have been outbreaks related to different strains of Candida auris that were first seen in South Asia, East Asia, South Africa, and Venezuela. We had a webinar recently on Candida auris.

VS How can physicians stay informed about these threats?

DeMaria We try to keep people aware. But if they want to be aware of more, and be aware of it earlier, they should subscribe to the CDC’s clinical alerts. ProMED-mail is an international system of communication about emerging and potentially emerging infectious diseases. Physicians can always call us if they have a concern.

Report Infectious Diseases
Call the Division of Epidemiology and Immunization at the Massachusetts Department of Public Health at (617) 983-6800 or (888) 659-2850 (days, nights, or weekends).

Improving Care Globally and at Home

By Robyn Alie, Manager, MMS Health Policy and Public Health

How does global health experience inform local practice? How can Massachusetts physicians help build medical capacity abroad? In January, the MMS New England Conference on Global and Community Health for Trainees explored opportunities and issues relating to practice in lower-resourced settings.

Vital Signs spoke with participants about the value and relevance of global health experience. For additional coverage, see massmed.org/vitalsigns.

Making High-Pressure Decisions

“In Ghana, trying to provide respite care for the doctors, the most challenging thing was making decisions about how to allocate limited resources. Do you give oxygen to the sickest kid, or the kid who is most likely to live? We are forced to make diagnoses without having many labs, without having any imaging. You’re really just focusing on what you can do. It forced me to grow in that way.”

— Diane Smith, MD, Lawrence Family Medicine Residency

Building Capacity

“I’m from Pakistan and there are a lot of patients in advanced stages of cancer. In the future, I am going to make a collaborative system between two institutions. Where I got trained is one of the [most] sophisticated hospitals in Pakistan, but it needs further development, especially in radiation oncology. Here, we have a lot of resources, but we need to learn to utilize them better.”

— M. Mohsin Fareed, MD, radiation oncology fellow, Brigham and Women’s Hospital, Harvard Medical School

Reciprocal Learning

“It works both ways. I work as a primary care physician in a community health center. I see patients from around the world. I would love to hear from providers who work in these areas around the world about health care there, because that helps me better understand what my patients [here] are seeking. Through shared learning, you can build these capacities without physically ever having been abroad.”

— Aditya Chandrasekhar, MD, MPH, Fenway Health
Local Lessons from Global Health in Allocating Medical Resources

GOVERNMENT AFFAIRS

BY SARAH RUTH BATES, MBE, MMS GOVERNMENT RELATIONS AND RESEARCH ANALYST

Dilemmas about how to allocate medical resources in disaster relief efforts or developing countries — which child gets medication? which wound merits a transfusion? — feel extreme. But they help highlight the reality that allocation decisions are also a routine, if less conspicuous, part of medical care delivery in the US, and it’s a new experience; “Oh, we can’t just give everybody IV fluids.” In Uganda you’re thinking about that all the time.”

Even in the US, some allocation decisions are so routine that clinicians may not be aware of them — “when we decide whom to admit to the hospital, whom to remove from intensive care, or whether every headache justifies an MRI,” says Dr. Eyal. Every time a physician decides not to spend an extra 10 minutes with a patient who could benefit from that, he or she is allocating a scarce resource.

Choosing Wisely

How can Massachusetts physicians incorporate resource stewardship into their daily clinical practice? Vital Signs spoke with two physicians who have worked to answer that question through Choosing Wisely, an initiative of the American Board of Internal Medicine Foundation aimed at helping patients and physicians “choose care that is supported by evidence, not duplicative of other tests or procedures already received, free from harm,” and “truly necessary” (according to ChoosingWisely.org).

Through Choosing Wisely, specialty societies identify common interventions — tests, drugs, and procedures — that are often high-cost and low-value, and issue guidelines encouraging physicians to think twice when ordering or prescribing them. The highlighted interventions “are not all bad or unnecessary,” says Dr. Ali S. Raja, MD, MBA, executive vice chair of the department of emergency medicine at MGH. “It’s more that these interventions are often overused.” Choosing Wisely gives patients and physicians a data-driven tool for reconsidering such interventions. “These guidelines come from the professional societies,” says Dr. Raja, who is also an associate professor at Harvard Medical School. Within their practice groups, physicians share data on individuals’ clinical practice relative to the interventions highlighted by Choosing Wisely, allowing outliers to adjust their decision making.

Patient-Centered Stewardship

Is “stewardship” just a more palatable way of saying “rationing”? Actually, Choosing Wisely is a patient-centered initiative. “I think the hard part here is the framing of the conversation,” says Thomas Isaac, MD, MBA, MPH, director of health care quality at Atrius Health. “It’s not, ‘We have to stop doing this or stop doing that.’ It’s that we need to do what’s right for the patient.”

“Testing can cause negative downstream effects,” says Dr. Isaac. Imaging for an acute flare of lower back pain without major medical risk factors, for example, is widely understood to be overused. The discussion with the patient should highlight potential harm, not costs: “Patients at low clinical risk who undergo an MRI early on are much more likely to receive other excessive testing and to undergo surgery that they don’t need.”

Choosing Wisely does benefit the health care system, and society as a whole — but, Dr. Raja says, physicians use it because it helps their patients. “The metrics that I choose are always somewhat patient-centered,” he says. “How long does the patient have to wait to see you? How many of your patients can you see? Are you ordering the right tests for your patients? If I emphasized the billing or revenue it would take a lot more convincing. You have to shift the frame to something that physicians can go home and feel good about.”

Who Owns Prevention?

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“It’s the question that I think we should be focusing on from a health and social policy perspective,” says Taylor, a doctoral candidate in health policy and management at Harvard Business School. “Historically, SDOH were thought of as a public health or social services job. It’s really a function of changes in the regulation and financing of medical care that have brought SDOH into the mainframe of what a health system is doing.”

Defining Health Systems’ Role

Movements toward greater population health through payment delivery models — such as accountable care organizations (ACOs) — undoubtedly expand the prevention purview of provider organizations. A Chicago-area hospital recently began subsidizing the housing costs for a cohort of patients with housing insecurity that were among the highest utilizers of emergency department services. The new MassHealth ACO model is intended to fund programs aimed at prevention through partnerships between ACOs and community organizations. But there comes a point at which even a broad-based entity responsible for population health cannot justify covering certain preventative programs (transportation, for example). In Taylor’s view, it would be poor policy, and unfair, to lay the burden of SDOH fully on the medical profession. On the other hand, she says, “I don’t see a vision of the future where health systems are just ‘doing medical care.’ So the question is how to bring medical professionals and health systems into the fold in a meaningful way and have them work with other types of professionals and organizations. The nitty-gritties of the integration of financing and care delivery are hard work, but I think that is the work before us.”

PWTF as Proof of Concept

Many believe the primary responsibility lies with government. In Massachusetts, the PWTF provides precedent. The initial trust fund was funded through assessments on payers and large hospital systems, and provided tailored, local interventions. These focused on four costly and prevalent health issues: pediatric asthma, falls in older adults, high blood pressure, and tobacco use.

In summer 2017, researchers at the Harvard Catalyst program released results of an evaluation of the first five years of the PWTF. The study confirmed that the PWTF “appears to be a very sound investment from the point of view of improving outcomes and controlling costs.” Clinical gains included a significant reduction in the blood pressure of patients and a projected decrease in falls by more than 3,000 incidents over five years.

How the PWTF Worked

“My sense was that the PWTF was able to achieve small-scale, meaningful two-way interactions between health organizations and community-based organizations or social service organizations,” says Taylor. “Perhaps most importantly, they worked through and around all of the HIPAA concerns. PWTF served as an important, local proof of concept.”

Legislative proposals supported by the MMS have been introduced to provide a sustainable funding source for the PWTF. The Medical Society strongly supports the prompt passage of legislation to refund and modernize the PWTF as an important step in addressing the social determinants of health of the patients of the Commonwealth.
Treatment, Translators, and Citizenship Forms: Caring for Immigrants in the Commonwealth

BY SARAH RUTH BATES AND KATE CONNORS

What are the health care consequences of fearing deportation? In 2018, as immigration status becomes less certain for many, physicians are finding out. “I’ve realized what a loaded question ‘How long have you been in this country?’ is,” says Elise M. Henricks, MD, medical director of Upham’s Corner Health Center in Dorchester, Boston, and a family medicine physician. “It used to be a standard social history question.”

Physicians caring for immigrants in Massachusetts are recognizing immigration status as a social determinant of health. “Two of my patients have had relatives incarcerated by the INS [Immigration and Naturalization Service], and others feel that they’re at risk, or their family members are. It’s changed the way that I ask people questions,” says Dr. Henricks.

Whole Patient Exemplified
Caring for immigrant patients requires physicians to surmount linguistic, logistical, and cultural barriers — but those difficulties create opportunities to make profound differences in patients’ lives. Supporting patients’ citizenship applications and connecting them with community resources are parts of this broad conceptualization of health care.

“I have incredible joy from helping my patients through the citizenship process,” Dr. Henricks says. “I take pictures of them when they come in with their passports, and I have a photo album of people who’ve come in with their new documentation status paperwork or their passport. It helps me realize that I have an important role in helping people to establish themselves here.”

Gained in Translation
The requirements of a multiethnic patient population start with overwhelming language differences. “Language barriers require extra effort on the part of both the patient and the office, or the health care system,” says Maryanne C. Bombaugh, MD, MBA, vice president of the MMS and a physician at the Community Health Centers of Cape Cod. “Language barriers can impact understanding, compliance, quality, and access to care.”

Upham’s Corner translates materials into four languages and hires bi- or trilingual staff from the community. At Cape Cod, staff and clinicians access live interpreter services online. Conversations that English-speaking patients might have with their physicians through letters or a patient portal — sharing test results, for example — may necessitate in-person visits for immigrants.

Understanding Cultural Differences
In these ways and more, care delivery requires a cultural shift in patients and providers. “So many layers of my patients’ stories impact how they think about taking their medication, or about time,” Dr. Henricks says. “Appointment times in other cultures can be much more vague; you just show up at the clinic and wait your turn to be seen.”

The health implications of cultural divides are described perhaps most memorably in The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures, by Anne Fadiman (Farrar, Straus and Giroux, 2012). The book, which explores conflicting ways to think about epilepsy, has become a staple of public health and medical education.

Cultural differences require interpretation, just as language differences do. “Vietnamese folks use cupping” — placing a cup on the skin and creating a vacuum or suction — “so women come in with marks that could look like bruises to someone who’s not familiar with the culture,” says Dr. Henricks. Staff from the local community serve as cultural (as well as linguistic) interpreters at Upham’s Corner. “No matter what you learned in medical school, you haven’t learned the cultural practices of all the people you’re going to be working with.”

Global Health Is Local Health
Global health experience may provide similar insights, says Arul Mahadevan, MD, a radiation oncologist. The clinical perspectives Dr. Mahadevan gains on his international medical trips — to countries including India, Bangladesh, and Tanzania — inform his care of patients at Radiation Oncology Associates and Lahey Hospital & Medical Center.

“It is important for us to be culturally sensitive and understand where our patients are coming from,” he says. “A lot of multilingual and multinational people are living here in Massachusetts. People come to this country with all their susceptibilities based on their cultural and habitual causes of cancer. It’s not just clinical medicine: It’s about the social issues and beliefs that patients bring with them.

“How do you relate to them, how you talk to them about treatments and palliative care? That’s very important for people practicing here in Massachusetts. Although we are calling it global health, it’s all local.”

Value for Providers
Given all of those challenges, how do these physicians caring for immigrants avoid burnout? “I’m very proud of the persons who work with me and the teams that care for our patients,” says Dr. Bombaugh. “These are very vulnerable patients, they’re underserved, and community health centers are places where all can truly be cared for.”

Dr. Henricks agrees. “I’m looking at my parking lot right now, and it’s completely packed. So is the waiting room. I’ve been here for 19 years, so I have patients that I’ve known since birth. The relationships with people make all the rest of it possible. And it’s such a group effort. Working with people who have a sense of the larger picture and the greater good keeps me going.”

MMS IT Awards Go to Mobile Apps

BY LEON BARZIN, MMS DIRECTOR OF HEALTH INFORMATION TECHNOLOGY

Mobile apps addressing opioid use disorder and medical education in neurology were the winning projects in the MMS Information Technology Award for medical students, residents, and fellows.

MySafeRx, a multi-component technological platform designed to address opioid use disorders, was created by Jackson Steinkamp, a third-year student at Boston University School of Medicine. The app, intended for patients, integrates text messaging, reminders, a secure electronic pill organizer, daily motivational recovery support, and a standardized protocol for supervised self-administration of naloxone. MySafeRx has demonstrated preliminary feasibility, usability, and acceptability. A larger randomized trial (n=70) comparing MySafeRx to standard care is underway.

NeuroCog is a searchable database of neurology physical examination questions designed to prime medical students ahead of patient encounters, freeing up time for bedside discussions. It was created by Stephanie Rutledge, MD, a second-year resident at Massachusetts General Hospital. The app provides high-quality 30-second video demonstrations of neurology exams, featuring consenting patients, with accompanying text and voiceover. The content was reviewed by experts to ensure rigor and credibility.

For 17 years, the MMS Committee on Information Technology (CIT) has taken pride in hosting the annual Information Technology Award competition. The finalists made live presentations to the committee, followed by extensive Q&A sessions. The two winners each received a prize of $3,000.

Jackson Steinkamp, from South Dakota, graduated from Harvard School of Engineering and Applied Sciences with a BA in computer science in 2015. Stephanie Rutledge, from Dublin, Ireland, obtained her medical degree from University College Dublin in 2013 and moved to Boston in 2016.

The 2018 awards program will open for applications on September 1, 2018.
Member News and Notes

Elisa I. Choi, MD, FACP (University of Medicine and Dentistry of New Jersey, 1996; residency: Beth Israel Hospital), has been elected governor of the MA Chapter of the American College of Physicians. Dr. Choi is an internist and infectious disease and HIV specialist in clinical practice and is on faculty at HMS. Dr. Choi serves as an appointed commissioner of the Commonwealth of Massachusetts Asian American Commission and chairs the Health and Human Services Committee.

Barbara J. McNeil, MD, PhD (HMS, 1966; residency: BWH), received the National Academy of Medicine (NAM) Walsh McDermott Medal in honor of her long-standing service to the National Academies of Sciences, Engineering, and Medicine. Dr. McNeil is the Ridley Watts Professor of Health Care Policy at HMS and a professor of radiology at HMS and BWH.

Thomas M. Michel, MD, PhD (Duke University School of Medicine, 1984; residency: BWH), was awarded the American Society for Pharmacology and Experimental Therapeutics (ASPET) 2018 Paul M. Vanhouthe Distinguished Lectureship in Vascular Pharmacology. Dr. Michel is a senior physician at BWH and a professor of medicine at HMS.

Michael E. Wagner, MD, FACP (Georgetown University School of Medicine, 1986; residency: Dartmouth-Hitchcock Medical Center, 1990), has been named chief physician executive at Wellforce, a health system created by Tufts Medical Center and Lowell General Hospital. Dr. Wagner, a primary care physician, has served as president and CEO of Tufts Medical Center and the Floating Hospital for Children since 2013.

Douglas C. Waite, MD (Rutgers Medical School, 1988; residency: UMass Memorial Medical Center), was named the new chief medical officer (CMO) of Covenant Health, a Catholic health care system serving New England. He is an infectious disease specialist and past CMO of St. Vincent’s Hospital, Worcester.

ACROSS THE COMMONWEALTH

District News and Events

NORTHEAST REGION

Charles River — Delegates Meeting. Wed., Apr. 18, 6:00 p.m. MMS Headquarters, Waltham. Delegates will meet to review and discuss the resolutions for Annual Meeting 2018.

Exxon South — District Annual Meeting. Tues., Apr. 3, 6:00 p.m. Spinelli’s Function Facility, Peabody. Speaker: MMS President-Elect Alain Chaoui, MD.

Exxon South/Exxon North — Joint Delegates Meeting. Tues., Apr. 10, 6:00 p.m. Beverly Depot, Beverly.

Middlesex — Annual District Meeting. Sat., Apr. 21, 6:00 p.m. DeCordova Sculpture Park and Museum, Lincoln. Includes dinner and dancing. Delegates Meeting. Wed., Apr. 25, 6:30 p.m. MMS Headquarters, Waltham. Delegates will discuss the resolutions for the Annual Meeting 2018.

Middlesex Central — Delegates/Executive Meeting. Thurs., Apr. 19, 7:45 a.m. Emerson Hospital, Concord.

Middlesex West — Delegates Meeting. Mon., Apr. 23, 6:00 p.m. MacPherson Hall, Framingham Union Hospital. Delegates will meet to review and discuss the resolutions for Annual Meeting 2018.


Norfolk South and Plymouth — Joint Spring Annual Meeting. Thurs., Apr. 5, 6:00 p.m. Lombardo’s, Randolph. Speaker: Todd Kerensky, MD. Topic: Prevalence of Non-prescription Fentanyl Use and Access to Drug Treatment in our Communities.

Suffolk — Delegates Meeting. Tues., Apr. 17, 6:00 p.m. East Garden Room, MGH, Boston. Delegates will meet to review and discuss the resolutions for Annual Meeting 2018. Northeast Regional Office: (800) 944-5562 or mjussaume@mms.org.

SOUTHEAST REGION

Barnstable, Bristol North, Bristol South, Norfolk South, Plymouth — Southeast Regional Caucus. Tues., Apr. 10, 6:00 p.m. LeBaron Hills Country Club, Lakeville.

Bristol North and Bristol South — Joint Spring Annual District Meeting. Tues., Apr. 3, 6:00 p.m. Venus de Milo, Swansea. Speaker: Gail Gazelle, MD. Topic: Mindfulness.


Hampshire — High School Doctor for a Day Program. Mon., Apr. 2, 7:30 a.m. Orientation, 4:00 p.m. Debriefing. Baystate Franklin Medical Center, Greenfield.


IN MEMORIAM

We also note member deaths on the MMS website, at massmed.org/inmemoriam.

Nubar K. Astarjian, MD, 83; Lynnfield, MA; Royal College of Medicine, Iraq; died January 10, 2013.

James A. Bougas, MD, 94; Weston, MA; Harvard Medical School, Boston; died October 28, 2017.

John J. Canfield Jr., MD, 77; Bluffton, SC; Georgetown University Medical School, Washington, DC; died January 2, 2018.

Daniel S. Ellis, MD, 104; Westwood, MA; Harvard Medical School, Boston; died December 13, 2017.

George A. Ellsworth, MD, 75; Brookline, MA; Harvard Medical School, Boston; died December 29, 2017.

Melvin I. Klayman, MD, 96; Palm Beach, FL; Tufts University School of Medicine, Boston; died January 13, 2018.

Robert H. Lofigren, MD, 86; Hingham, MA; Boston University School of Medicine; died August 19, 2017.

John A. Lynch, MD, 96; North Falmouth, MA; Tufts University School of Medicine, Boston; died October 27, 2016.

James R. Ralph, MD, 84; Amherst, MA; Yale School of Medicine, New Haven; died December 21, 2017.

Elizabeth A. Reid, MD, 85; Lexington, MA; Columbia University College of Physicians and Surgeons, New York City; died February 19, 2012.

Jonathan P. Rorove, MD, 75; Lakewood Ranch, FL; SUNY Downstate Medical Center, Brooklyn; died December 6, 2017.

Burton Sack, MD, 80; South Easton, MA; State University of New York; died January 20, 2018.

Martin R. Santis, MD, 80; Acton, MA; Tufts University School of Medicine, Boston; died June 16, 2017.

Jules R. Setnor, MD, 101; Longmeadow, MA; SUNY Upstate Medical University, Syracuse; died December 21, 2017.

Charles A. Swanson, MD, 68; Boxford, MA; Stanford University School of Medicine; died October 25, 2017.

Fortunato C. Torreyap, MD, 93; Arlington, MA; University of The Philippines College of Medicine; died January 24, 2018.

William W. Walthall Jr., MD, 88; Westborough, MA; Virginia Commonwealth University School of Medicine; died February 27, 2012.
THE GLOBAL HEALTH ISSUE

1. What to Expect of Global Health
2. President’s Message: Is All Health Global Health?
3. Who Owns Prevention?
4. Physician Leader Who Built the Member Interest Network
5. Improving Care Globally and At Home
6. Local Lessons from Global Health in Allocating Medical Resources
7. Caring for Immigrants in the Commonwealth
8. MMS IT Awards Go to Mobile Apps
9. Across the Commonwealth

MMS AND JOINTLY PROVIDED CME ACTIVITIES

LIVE CME ACTIVITIES
Visit massmed.org/cme/events.

2018 Ethics Forum — Transparency in Health Care
Thursday, April 26, 2018 (Seaport Hotel, Boston, MA)

2018 Annual Education Program — Epidemics Going Viral: Innovation vs. Nature
Friday, April 27, 2018 (Seaport Hotel, Boston, MA)

Bleeding Control for the Injured/Stop the Bleed Training
Friday, April 27, 2018 (Seaport Hotel, Boston, MA)

ONLINE RISK MANAGEMENT CME ACTIVITIES
For these and other online CME activities, visit massmed.org/cme.

Firearm Violence: Policy, Prevention, and Public Health (6 modules)
Module 1: Reducing Firearm Injury and Opening Remarks
Module 2: Unintentional Firearm Fatality and Suicide
Module 3: Changing the Conversation about Firearms
Module 4: Community-Based Prevention
Module 5: Evaluating the Risks for Gun Violence in Patients
Module 6: Role of the Clinician

Initiating a Conversation with Patients on Gun Safety
Talking to Patients about Gun Safety
Workplace Violence against Health Care Workers in the United States

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

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