Hiding in Plain Sight: How Clinical Ethics Shape Everyday Care

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

Bioethics tends to bring to mind the “big” questions: Should a patient with terminal cancer get access to an experimental therapy still in trial? Should geneticists modify the human germline to prevent genetic diseases? These are examples of ethics in the headlines. But ethical dilemmas come up in daily clinical care, too; we just may not recognize them as such.

For example, when a procedure carries a small risk of death, should anesthesiologists use the D word? Anesthesiologists vary widely in their answers to this question, says Robert D. Truog, MD, director of the Harvard Medical School (HMS) Center for Bioethics, professor of medical ethics, anaesthesiology, and pediatrics at HMS, and lead author of the seminal article “Microethics: The Ethics of Everyday Clinical Practice” (Hastings Center Report, 2015). “Some never [say ‘death’]; some always do. Relational judgments like these are rarely framed as ‘ethical’ decisions. Yet these kinds of choices arise in everyday clinical encounters, and even seasoned professionals struggle with how to think about them,” says Dr. Truog.

Everyday Microethics

The term microethics refers to such everyday quandaries. Even physicians who don’t think they encounter ethical dilemmas in their work actually do, says James E. Sabin, MD, professor of population medicine and psychiatry at HMS. Dr. Sabin, who also directs the ethics program at Harvard Pilgrim Health Care, interviewed physicians for a book on ethics. He asked them to list ethical issues that came up frequently in their work, and they often couldn’t think of any. Then he asked, “What keeps you up at night? What worries you? What concerns you?” They started talking, he says, and “all sorts of things emerged that we would put under the heading of ‘ethics.’”

The link between ethics and what physicians care about runs deep, says Lachlan Forrow, MD, associate professor of medicine at HMS, and director of ethics and palliative care programs at Beth Israel Deaconess Medical Center (BIDMC). “The words ‘moral’ and ‘morale’ come from the same word in Latin, suggesting that 2,000 years ago in Rome you couldn’t even think of one without the other.” Dr. Forrow’s metric for ethical care reflects that link: “Every physician should go home justifiably proud of the care they’ve given, and every patient should go home justifiably grateful for the care they received.” Collaborating with ethicists can help to achieve that goal. Never worry alone, he tells his colleagues. At BIDMC, “ethics is everyone,” embracing the entire clinical team and staff.

Ethics as the Physician’s Calling

Ethics can be defined positively as well. It has roots not just in what worries physicians, but also in what brings them to medicine. “Ideally,” Dr. Sabin says, “one can understand ethics as what makes us get up in the morning, see our patients, and have the privilege of taking care of people. Ethics is at the core of what our profession is about. It’s the essence of our identities as physicians, and our basic forms of caring about our patients, our profession, and our societies — the meaningful moments that come out if you talk to colleagues about why you went into medicine in the first place, or what experiences bring you joy as you recollect them.”

Ethics Facilitates Care

Ethicists can help with working effectively together through difficult cases — though this may surprise some physicians, who “associate the word ‘ethics’ with reproach and scolding,” says Dr. Sabin. The ethicist’s job is not to correct bad behavior, but rather to facilitate “collaboration around shared ideals.”

“Every physician should go home justifiably proud of the care they’ve given, and every patient should go home justifiably grateful for the care they received.” Collaborating with ethicists can help to achieve that goal. Never worry alone, he tells his colleagues. At BIDMC, “ethics is everyone,” embracing the entire clinical team and staff.
Physician Well-Being Supports Patient Well-Being

It is one of the greatest honors of my professional life to address you, friends and colleagues, in my first president’s message.

I knew when I became part of the Massachusetts Medical Society that I was joining one of the most prestigious and well-respected medical communities in the world. It was clear to me that the MMS was driven to excellence by its membership and its leaders, and that the Medical Society possessed a shared, passionate, and influential voice used for good — for the good of those we have dedicated our lives to keeping healthy.

To most effectively heal our patients, we cannot forfeit our own well-being. If we are not wholly healthy, we simply cannot provide to our patients care that meets their needs and standards. Nor can we satisfy our personal and organizational standards of compassion, professionalism, excellence, and accountability that I know inspire each of us, every day, in each patient interaction.

We have an obligation to present to our patients our best selves. That obligation should be held sacred within the family that is the MMS. We should not only accept the responsibility of checking on each other, but feel gratified in doing so, recognizing that our health is, in fact, a vital part of patient safety.

We should feel comfortable in confiding in each other, and in offering and accepting guidance within this abudantly close and supportive community, especially when our diminished level of wellness could jeopardize patient outcomes (see page 6).

I look forward to working closely with you to address the many challenges we face, while embracing opportunities to improve our practice and the health of our patients.

— Alain A. Chaoui, MD

omedical Injury Disputes

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openly with a patient and say, “I’m sorry,”” says Dr. Woodward, who is a past president of the Massachusetts Medical Society and past chair of the MMS Committee on Professional Liability. “It helps defuse patient anger and provider grief while maintaining trust and focusing on the patient’s medical and psychosocial needs and prevention of recurrences.”

The CARe model is based on rapidly initiating communication following a patient injury. The physician, or an appointed hospital or facility representative, meets with the patient (and/or their family) to explain what happened, express regret, and discuss the next steps for patient care and support.

A subsequent investigation leads to a determination about whether the patient’s injury was caused by medical mismanagement. If so, the CARe team, including facility and insurance company representatives, moves into the resolution phase, which may include discussions about compensation.

The CARe model functions whether or not there is a determination of medical mismanagement because of its emphasis on regular communication and on improving patient safety.

In a paper published in Health Affairs in 2017, the authors report that in a large majority of cases reviewed, the standard of care was met. The CARe model seeks to provide the information and empathy that patients need to process the event and understand that it does not merit legal redress.

In the cases in which the standard of care was not met, or the care was determined to have been unreasonable, the patients received an apology. Resolution efforts were initiated, including compensation when appropriate. The median compensation payment was $75,000; only 5 percent of care events led to malpractice cases or lawsuits.

The CARe model can dramatically slash the time required to achieve resolution, compared with the “deny and defend” model — down from multiple years to roughly nine months, says Dr. Woodward. “The experience of going through litigation for many years is horrific for physicians, and even if they win, the toll is the self-doubt, persistent stress, and sleepless nights.”

According to the Health Affairs paper, 7 out of 10 clinicians who self-reported as knowing enough about the CARe system to answer questions on it gave strongly positive reviews. One finding of the survey was simply that more clinicians should know about the model.

Working through the CARe process can also lead to patient safety improvements. In an early analysis of preliminary data reported in Health Affairs, more than 40 percent of cases gave rise to a safety improvement action.

Newton-Wellesley Hospital, which adopted the CARe model in mid-2017, has already experienced positive outcomes. Jodi Larson, MD, chief quality and experience officer, described a situation in which patient care had suffered due to communication failures. Improved communication, she says, turned the experience around. “The patient was grateful that we were transparent with her. The caregivers were grateful that they could tell her what had happened and apologize for it. The providers were able to talk about it with each other rather than worry in isolation.”

Regarding another, yet-unresolved situation, Dr. Larson observes that without the CARe model, which has supported both the physician and the patient, “the attending would have been left to his own to deal with the emotional burden of the case.”

A team-driven, communication-based approach to resolution, she says, keeps the attention on patient outcomes, rather than on litigation or reputation management. “Involving the patient in the discussion and keeping the focus on the patient, who is a real-life person that we all have connected with and formed a meaningful relationship with, has been so powerful,” says Dr. Larson.

“It reminds us of the importance of our job and connects us back to why we decided to work in health care.”

MACMI’s 6th Annual Forum will take place on May 15, 2018, from 10:00 a.m. to 2:30 p.m. at MMS Headquarters, Waltham. Learn more at macmi.info.

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Ethical Dilemmas: Terminating a Patient-Physician Relationship

BY JILLIAN PEDROTTY, MHA, SENIOR SPECIALIST, MMS PHYSICIAN PRACTICE RESOURCE CENTER

When physicians encounter patients who routinely don’t pay their bills or are extremely difficult to work with, they may think about dismissing these patients from their panel. This is not an easy decision. Physicians have an ethical duty to promote continuity of patient care, and may fear being accused of patient abandonment. The medical profession is increasingly, and appropriately, tuned into the factors that can make self-care and appointment adherence challenging for patients. Sometimes physicians may continue to work with problematic patients, even to the detriment of their own well-being. In certain circumstances, however, physicians can reasonably terminate a patient relationship.

Identifying the Reason for Termination

Typically, a physician’s relationship with a patient ends for one of several reasons: the patient seems unable to follow the treatment plan and care recommendations; the patient is verbally or physically abusive; the patient continuously does not pay their bill; or the patient repeatedly misses appointments. Patient-providers cannot be legally terminated for discriminatory factors such as race, ethnicity, gender, disability, age, religion, or sexual orientation.

Physicians considering the termination of a patient have several factors to weigh. Increasing recognition of the social determinants of health has provided insight into why patients may not make their appointments or follow treatment recommendations. Barriers outside patients’ control may include certain disabilities or illnesses, reactions to medications, literacy or language issues, financial hardship, social challenges (such as domestic abuse), and logistical or environmental factors (for example, inadequate transportation or housing). For this reason, the term “noncompliant patient” has fallen out of use. Contemporary practice models and standards of care emphasize respect for the “whole patient,” shared medical decision making, and the patient-centered medical home as a means of lowering or navigating some of the barriers.

Allowing Course Correction

When considering terminating a patient-physician relationship, it is good practice to allow patients an opportunity to rectify the situation. Physicians cannot terminate a relationship with a patient because they haven’t paid a bill, for example — but if the patient continues to receive care and not pay for it, the practice staff should attempt to work out a payment plan with the patient. If the patient continues not to pay, the practice can consider terminating the relationship.

Clarifying Patient Abandonment

Patient abandonment is typically defined as the unilateral severance by the physician of a patient-physician relationship, without giving a patient sufficient advance notice to obtain the services of another practitioner. These claims are a tort, similar to negligence, and can induce significant liability, fines, restrictions, and/or the loss of a professional license.

Steps to an Ethical Termination

Once a physician has identified a reason for termination, they should consider these steps:

• Review contracts and communicate with health plans: It’s important for physicians to review their health plan contracts, especially for the patient in question, and check for clauses regarding the termination of a patient-physician relationship. Alternatively, a physician can contact the patient’s health plan and discuss next steps to ensure the termination is handled according to the terms of the contract.

• Provide written notice: A physician should send a written notice to the patient, preferably by certified mail with a return receipt requested. This provides evidence that they communicated the end of the relationship with the patient. The notice to the patient should include the following:

  – A brief explanation for terminating the relationship; the details should be documented in the patient’s record
  – An agreement to continue to provide treatment for a reasonable period of time to allow a patient to secure care from another physician
  – The date the termination will be effective; typically, 30 days is sufficient, but the time period may need to be extended based on the patient’s condition, payer contract, or access of care
  – Advise that the patient contact their health plan for a list of alternative providers within their network
  – An offer to transfer records to a newly designated physician upon signed patient authorization to do so
  – Communicate with the entire staff: A physician should inform the entire practice staff of the end of a relationship with a patient to avoid accidentally re-establishing that relationship.

Are You Having Problems Getting Paid?

MMS Regional Offices to Host In-Person Claims Review Sessions with Massachusetts Payers

The MMS Regional Offices have scheduled the annual Individual Claims Consultation Days for July, August, and September 2018. These in-person troubleshooting sessions are designed to allow MMS member physicians and their practice staff to schedule 30-minute appointments with health plan representatives to adjudicate troublesome claims and facilitate processing. Schedule your appointment at massmed.org/iccdays2018.

The following health plans are participating: BCBSMA, BMC HealthNet Plan, Fallon Community, Harvard Pilgrim Healthcare, Health New England (at the Holyoke session only), MassHealth, Medicare, Neighborhood Health Plan, Tufts Health Plan, and United Healthcare.

FACE-TO-FACE DISCUSSION OF CLAIMS

July 25 9:00 a.m.–4:00 p.m.
August 16 9:00 a.m.–4:00 p.m.
September 20 9:00 a.m.–4:00 p.m.

“I had a significant claims concern. Being able to speak person-to-person to a representative was so much better than being on hold on the phone. I would recommend that members take advantage of this useful service that the MMS supplies.”

—Laura L. McCann, MD, president, Charles River District Medical Society

CALL 781.434.7702
EMAIL pprc@mms.org
CLICK massmed.org/pprc
Providers versus Patients: The MMS Grapples with Ethics in Public Health Policy

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

If a health care worker is exposed to a patient’s body fluids in the workplace, should the patient be required to undergo HIV testing? This issue, the subject of discussion at the 2018 MMS Annual Meeting, exemplifies the ethical dilemmas that come up in policy and advocacy within the MMS and in public health broadly.

Laws, institutional policies, and professional ethical guidelines often provide clear guidance on how physicians must practice medicine. When considering new laws or policies, or the repeal of existing ones, the rights or needs of one individual or group may be weighed against those of another. Should schools or pediatric practices require children to be immunized? Under what circumstances should an individual be quarantined? Should health care workers be allowed not to treat certain populations based on their own moral or religious beliefs?

Mandatory HIV Testing

At last year’s annual meeting, delegates considered a member-proposed resolution that the MMS advocate for the mandatory HIV testing of patients when a health care worker is exposed to potentially infected body fluids in the hospital. Testimony at the reference committee highlighted the complexity of the issue, prompting a vote to have the MMS further study it.

Thirty-five other states have laws allowing for some form of unconsented testing following health care worker exposure to body fluids. Massachusetts requires informed consent. Many Massachusetts hospitals require separate written consent beyond their legal obligation.

Impact on the Health Care Worker

The risk of an occupational exposure resulting in a health care worker contracting HIV is extremely low. No reported conversions have been reported in Massachusetts in 20 years, and in the last case the source was unknown. In addition, HIV is now a treatable disease. Those facts, however, may not eliminate the anxiety of the health care worker facing post-exposure prophylaxis or a possible lifelong HIV infection.

Impact on the Patient

Knowledge of one’s HIV status can benefit the source patient — for example, by linking a seropositive patient to early treatment and support. Almost all patients consent to HIV testing following possible worker exposure and there are procedures for obtaining consent for incapacitated patients.

Some argue that HIV is no longer stigmatized, and exceptional policies around HIV may themselves create stigma and inhibit care. But reports indicate that people with HIV continue to experience discrimination and stigma, and that may affect individuals’ health and health care.

Ethical and Other Issues

The proposal to test without patients’ consent raises a number of ethical and other issues for physicians: Is it ethical to perform a procedure on a patient without the patient’s informed consent — particularly when that test is explicitly for the benefit of someone else?

If a patient refuses consent, will blood be forcibly drawn? What precedent would such a law create for exposures that occur outside the hospital, where privacy rules do not apply? What abuses might result? What are the legal implications of such a policy? What impact could it have on the patient-physician relationship, and on patients’ trust in their health care providers?

The committees charged with making a recommendation on this resolution identified the opportunity to reduce the risk of occupational exposure and to improve support for affected patients and health care workers.

Citing the ethical principles of patient autonomy, and the primary of the physician’s responsibility to the patient, the committee recommended against the Society advocating for unconsented HIV testing.

The Evolution of Death: Bioethicists’ Ongoing Effort to Define End of Life

BY BRENDAN ABEL, JD, MMS LEGISLATIVE AND REGULATORY AFFAIRS COUNSEL

Fifty years ago, 20 miles from the Medical Society’s headquarters, a group of physicians was tasked with redefining the most essential concept in the practice of medicine: death. Their revised definition of death, driven by technological advances, was subsequently codified into law.

Today, physicians and ethicists are again debating concepts of death. Brain imaging technologies are challenging our long-held concepts of “total brain death.” Some are pushing for a more stringent, holistic concept of brain death, while others lean in the opposite direction, focusing on concepts of irreversible consciousness.

If anything seems absolute, if any state of being seems fixed, it is death. But, like everything else in medicine, death evolves, reminding us that bioethics is not confined to hypertechnical matters, such as gene editing or nanotechnology. Bioethics extends to matters that will affect every one of us — including how our life and death will be defined.

Implications of Technology

The definition of death illustrates the paramount importance of bioethics to the practice of medicine, now and in the future. Technological advances will continue to displace longstanding tenets of medicine. Bioethics will continue to be an essential tool as the medical community addresses these issues in the name of upholding the highest ethical standards for patients and for the profession.

Until the 1970s, the definition of death had seemed simple. A person died when they stopped breathing, their heart stopped beating, and their body turned blue and cold. Two converging technological advances — ventilators/life support and organ donation — challenged this.
**Evolution of Death**

Life support could keep a patient’s heart beating into perpetuity, creating a quandary: “living” patients whose hearts pumped blood through their warm bodies, but whose brains had ceased to function. And organ transplant, which was premised upon the ethical tenet that a patient must be dead before an organ could be obtained for donation, suddenly put a keen importance on the precise moment of death. In this new world, death needed to be redefined.

**Harvard’s Definition of Death**

A committee of physicians and researchers at Harvard Medical School convened for that purpose. The Ad-Hoc Committee of Harvard Medical School to Examine the Definition of Brain Death issued a report that, for the first time in the United States, proposed a new concept: brain death. “A Definition of Irreversible Coma” was published in JAMA in 1968. Patients could now be determined dead by either the traditional definition — cessation of cardio-pulmonary function — or the new criterion of a “permanently nonfunctioning brain.”

It took some time for the Ad-Hoc Committee’s definition of brain death to become law. In 1980, a physician in Washington who defined death via the Committee’s standard was sued for advising that medical intervention end in the case of a brain-dead patient. This prompted all 50 states to codify in law the bi-definitional concept of death, affirming a place in bioethical history for the Ad-Hoc committee.

**Case in Microethics: Is It OK to Hug Your Patient?**

BY SARAH RUTH BATES, MBE

A recent Ethics Case Conference at BIDMC focused on when it is and isn’t appropriate to hug patients. “There was an instance of a physician who didn’t hug a patient, left the room, and thought, I didn’t hug this patient, and I normally do. Why didn’t I? They felt that the gesture could have been misconstrued,” says Zachary S. Sager, MD, palliative care fellow at BIDMC, and a panelist for the case conference.

**Power Dynamics**

The conference focused on the ways that power dynamics, such as those present in the patient-physician relationship, can complicate and shape even well-intended overtures. The #metoo movement has helped to make those dynamics visible. This is not to equate hugging a patient with the harassment and abuse that #metoo has unearthed. But discussions of that harassment and abuse have illuminated subtle ways in which power dynamics alter the valences of our actions, whether at a movie set, in an office, or at a hospital. “We need to pause and think about why and whether we should touch patients: What will be the impact of this touch?” says Reverend Katie P. Rimer, MDiv, EdD, BCC, another conference panelist.

**Cultural Awareness**

Ethicists consider factors that others may not, such as cultural awareness. Rev. Rimer, who directs spiritual care at BIDMC and cares for patients entirely, however, they may lose a valuable element of care. “Hug patients, and sometimes healing, that comes from touch.” In terms of principles, that means respecting patients’ autonomy, and honoring the principle of nonmaleficence — not causing harm — while also weighing beneficence, the duty to provide the best possible care. The very fact of hospitalization compromises patients’ autonomy, as does the patient-physician power dynamic.

**Best Hugging Practices**

If physicians stop hugging their patients entirely, however, they may lose a valuable element of care. “Hugging them conveyed my condolences, and made me feel less doctorly and more human,” says Dr. Sager. Rev. Rimer agrees: not hugging a patient “could be withholding optimal care.”

What’s a doctor to do? The panelists suggested nonphysical ways of offering comfort, as an alternative to hugs. "Just me being present, and being silent, and saying that I’m sorry for your loss, can convey the same level of emotion as a hug,” says Dr. Sager.

They also agreed on asking patients verbally before offering a hug. “If you ask, you empower the person, and it can open up a conversation,” says Dr. Sager. “It makes medicine relational.” Betsy Lowe, a BIDMC patient advisor, and also a panelist, recalls a physician asking her if she wanted a hug. “I felt strong enough to say, actually, no, that wouldn’t be helpful. If he had offered me a hug without asking, I probably would have just received it, and would not have left feeling any more comforted than before.”

James E. Sabin, MD, director of the ethics program at Harvard Pilgrim Health Care, offered another best practice: an “A-frame hug, with no chest-to-chest contact.” That posture allows for “a gesture with minimal actual bodily contact,” while still providing comfort.

“Nothing therapeutic in medicine has zero risk,” says Lachlan Forrow, MD, director of ethics and palliative care programs at BIDMC, “but everything should be done carefully and respectfully.” Such dilemmas are “not rocket science,” says Dr. Sabin. “Our response should ideally match what we would come up with if we were reflecting on this situation in a leisurely discussion.”

The reporter has a master of bioethics from Harvard Medical School.

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**Past Trauma**

Individual patients’ pasts — those disclosed and undisclosed personal histories — also matter. “Trauma-informed care” asks clinicians to “presume someone has been through trauma and then act accordingly, which would certainly point us toward not presuming to touch,” says Rev. Rimer.

**Weighing Moral Principles**

Ethicists tackle dilemmas such as this by identifying the relevant tensions. In this case, Rev. Rimer says, the goal is to find “guidelines that are respectful of people while preserving the intimacy, and sometimes healing, that comes from touch.” In terms of principles, that means respecting patients’ autonomy, and honoring the principle of nonmaleficence — not causing harm — while also weighing beneficence, the duty to provide the best possible care. The very fact of hospitalization compromises patients’ autonomy, as does the patient-physician power dynamic.

**GOVERNMENT AFFAIRS**

**Evolution of Death continued from page 4**

Ethicists generally weigh in through case consultations. At some institutions, an attending can call for an ethics consult in the same way they would call for a nephrologist or a cardiologist. Patients and families can call for ethics consultations as well. The consult itself can take myriad forms: an ethicist or group of ethicists meeting with the clinician(s), the patient and/or family, sometimes repeatedly; or a committee convening to discuss the case, deliberate on the best course of action, and issue recommendations.

**Ethics Consultations**

A particularly troubling case, one that highlights the need for a policy change, or is emblematic of an issue that arises frequently, might occasion a case conference, similar to a morbidity and mortality review. In addition, some ethicists conduct regular rounds with clinical staff, most often in acute care settings such as the ICU or the ER. Those rounds allow staff members to talk through ethical issues that arise in their practice.

Large institutions tend to offer more robust ethics programming. Most small and independent practices lack access to such services. The paucity of ethicists is due in part to the relatively recent emergence of ethics as a profession. Bioethics has, in a sense, existed for as long as physicians have practiced medicine, but bioethics as a discipline is still being defined. Physicians who lack access to institutional ethics services can connect with the Society’s Ethics and Grievances Committee, which holds two Ethics Forums per year (at the Annual Meeting and the Interim Meeting).
How to Support a Colleague Who’s Impaired or Incompetent at Work

BY DEBRA A. GROSSBAUM, JD, GENERAL COUNSEL, PHYSICIAN HEALTH SERVICES

We all aim to be supportive to our colleagues, especially when we know that they may be struggling with personal or health-related problems. But what is our obligation when a personal issue seems to undermine a physician’s ability to provide medical care with optimal skill and safety?

Physicians, like everyone else, are susceptible to stressors and challenges that can derail their focus and attention. Unlike most other professionals, though, physicians do not have the leeway to perform at anything less than full competence. Patients enter the medical environment trusting that their physicians will be not only sufficiently trained, but also fully alert and well enough to apply their medical training to patients’ specific needs. As a theoretical matter, few would disagree.

Most Physicians Act on Concerns

Most physicians are ready to act on this obligation. In a survey involving 3,000 physicians, two out of three (64 percent) agreed with the professional commitment to report physician colleagues who are impaired or incompetent to practice (JAMA, 2010). Seventeen percent of respondents said they had personal knowledge of such a physician, and two in three of them (67 percent) had reported that colleague.

The most frequently cited reason for not reporting an incompetent colleague was a belief that someone else would address the problem, a belief that nothing would happen as a result, and fear of retribution. It may be helpful to recognize that allowing a potentially impaired physician to continue to work is detrimental to the physician as well as patients, and to learn the options for positive intervention.

Legal and Ethical Obligations

Under the “mandated reporting law,” physicians and other health care professionals are required to report to the Massachusetts Board of Registration in Medicine whenever they have a reasonable basis to believe that a physician could be impaired in his or her ability to practice medicine (Massachusetts General Laws, Chapter 112, section 5F). Beyond these legal obligations, there are ethical reasons to act. Physicians are sworn to “do no harm,” and have a clear obligation to ensure that they and those with whom they practice are fit to provide care.

Encourage Time Off

Several options may help mitigate concerns about addressing a colleague’s work performance. The sooner these steps are taken, the less likely it is that a physician’s ailment will become an impairment. First, ailing physicians must take time off work whenever their optimal performance is at stake. This can be encouraged by effectuating policies that not only allow, but actually encourage, time off to address illness. There is no fault or shame in being ill, and the medical workplace, of all professional environments, should create opportunities for wellness. In addition to taking days off as needed, physicians should be afforded nonpunitive leaves of absence to address health matters that require more significant intervention or long-term attention.

Refer to Physician Health Services

For colleagues who do not or cannot acknowledge their own health vulnerabilities, physician health programs (PHPs) can facilitate objective, independent, and confidential assessments, and make recommendations when remediation is indicated. In Massachusetts, the PHP is Physician Health Services, Inc. (PHS), which serves as an important resource when colleagues are unsure what may be ailing a physician and are reluctant to probe or compromise confidentiality. In such cases, the workplace can remain at arm’s length from a colleague’s personal matters while the PHP determines whether there is a health issue that requires some type of accommodation or remediation. Referrals to PHS are easily made, and only proceed with the agreement and cooperation of the referred physician.

While it can be a challenging burden to be each other’s keepers, the duty to keep a watchful eye does fall all health care providers, both legally and ethically. We need to work together so that this mutual duty is executed in a caring and supportive manner, in order to best benefit physicians and patients alike.

How to Refer a Colleague to Physician Health Services

Anyone can call PHS to make a referral — a supervisor, colleague, spouse, or the physician in need of services. For the referral to proceed, the physician must agree. PHS is a peer-review organization. Our records are protected and confidential, and we are a fully independent subsidiary of the MMS, with the goal of identifying, supporting, and monitoring physicians and medical students who are experiencing or are at risk for health-related concerns. For all PHS services, please call (781) 434-7404.

Coming Soon: Sharing More Health Data via the Mass HIway

Medium and large physician organizations will be expected in the coming months to more actively share health data via the state health information exchange. This summer, the Massachusetts Executive Office of Health and Human Services (EOHHS) will implement a 2012 legislative mandate regarding the interoperability of electronic health records (EHRs). To see if you are affected, and for more details, see massmed.org/interoperability. The MMS opposes the mandate, and staff will continue our advocacy efforts to minimize the burdens on physicians. We will also work with you to answer questions regarding compliance.

The mandate, as interpreted via regulations promulgated last year, places an emphasis on interoperability through connection to the Mass HIway, the state health information exchange. The regulations outline various examples of how practices can incorporate Mass HIway usage into their practice to fulfill the mandate — for example, by using the Mass HIway to regularly report data to the Massachusetts Department of Public Health.

At the strong urging of the MMS, the requirements for interoperability have been tailored by practice size; small ambulatory practices are presently excluded. The MMS will continue to work with the EOHHS and other stakeholders as we near the implementation date. We expect communications from the EOHHS to go out to physicians this summer.
MMS Member News and Notes

Omar Arnouit, MD (Northwestern University School of Medicine, 2010; residency: Northwestern Memorial Hospital), and Timothy R. Smith, MD, PhD, MPH (UCLA School of Medicine, 2003; residency: Northwestern Memorial Hospital), have opened a new practice — Brigham and Women’s Neurosurgery of Milford — in the Milford Regional Medical Center. The team, including Hasan Zaidi, MD, treats spine and brain conditions. Dr. Arnouit and Dr. Smith are both on the faculty at HMS.

Mark R. Dumais, MD, MBA, FACP (HMS, 1994; residency: Duke University Hospital), was named chief medical officer at Mercy Medical Center, an affiliate of the Trinity Health network. Dr. Dumais was previously in the Hospital Medicine Unit at MGH, an instructor in medicine at HMS, and chief medical officer at the University of Maryland Charles Regional Medical Center.

Paul E. Farmer, MD, PhD (HMS, 1990; residency: BWH), received the 2018 Public Welfare Medal, the most prestigious award of the National Academy of Sciences, honoring his extraordinary use of science for the public good. Dr. Farmer is cofounder and chief strategist of Partners In Health, Kolokotrones University Professor of Global Health and Social Medicine at Harvard University, and chief of the Division of Global Health Equity at BWH.

Juhee C. McDougal, MD (University of Texas Southwestern Medical School, 2013; residency: Boston University), has been elected secretary/treasurer of the Society of General Internal Medicine’s New England region. Dr. McDougal, an internal medicine specialist, is an attending physician at BUMC and an instructor of medicine at BU School of Medicine.

Deeb N. Salem, MD, FACP, FACC, FAHA (Boston University School of Medicine, 1968; residency: USPS Hospital), was named physician co-interim CEO at Tufts Medical Center. Dr. Salem is physician-in-chief at Tufts Medical Center, Sheldon M. Wolff Professor and chair of the Department of Medicine at Tufts University School of Medicine, and a recipient of the MMS Special Award for Excellence in Medical Service, honoring his distinguished cardiology career and his services to the medical community.

Eren D. Yeh, MD (George Washington University School of Medicine, 1991; residency: Mt. Auburn Hospital; fellowship: MGH), received the American Journal of Roentgen Ray Society Award from the American Roentgen Ray Society. Dr. Yeh, a radiologist, practices at BWH and is an assistant professor of radiology at HMS. Dianne Georgian-Smith, MD, another BWH radiologist, also received the award.

IN MEMORIAM

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

Richard M. Cresssey, MD, 73; Andover, MA; University of Toledo College of Medicine; died November 8, 2017.

Robert J. Donohue Jr., MD, 88; Holyoke, MA; Yale University School of Medicine, New Haven; died March 1, 2018.

LeRoy L. Eldredge Jr., MD, 97; Hingham, MA; Tufts University School of Medicine, Boston; died October 5, 2017.

Paul Griffeld, MD, 65; Framingham, MA; Universidad Autonoma de Nuevo Leon, Mexico; died August 9, 2017.

Bruce Hauptman, MD, 79; Lexington, MA; New York Medical College, Valhalla; died November 11, 2017.

Gustave A. Laurenzi, MD, 90; Wayland, MA; Georgetown University School of Medicine, Washington, DC; died November 9, 2016.

Nathaniel A. MacDonald, MD, 95; Danvers, MA; Tufts University School of Medicine, Boston; died December 20, 2017.

George J. Mansour, MD, 98; Lawrence, MA; Georgetown University School of Medicine, Washington, DC; died December 3, 2017.

Ronald J. Messer, MD, 84; Marshfield, MA; Harvard Medical School, Boston; died April 27, 2017.

Richard Porter, MD, 92; Peabody, MA; Tufts University School of Medicine, Boston; died January 29, 2018.

Isadore N. Rosenberg, MD, 98; Newton, MA; Harvard Medical School, Boston; died February 2, 2018.

James M. Seltzer, MD, 65; Encinitas, CA; University of Pennsylvania School of Medicine, Philadelphia; died December 8, 2016.

Desmond R. Tivy, MD, 89; Lenox, MA; King’s College London, UK; died December 5, 2017.

Resources for Your Patients with Serious Illness

How can patients and their loved ones navigate serious illness and the end of life in ways that honor their goals and values? In the current episode of Physician Focus, Robert Schreiber, MD, vice president and medical director of the Program of All-Inclusive Care for the Elderly at Fallon Health, and Lachlan Forrow, MD, director of ethics and palliative care at Beth Israel Deaconess Medical Center, outline the steps. The episode is available at massmed.org/physicianfocus. Physician Focus is a public access television show produced by the MMS and HCAM-TV.

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   - A Collaborative Path through Medical Injury Disputes

2. President’s Message: Physician Well-Being Supports Patient Well-Being

3. Terminating a Patient-Physician Relationship
   - Are You Having Problems Getting Paid?

4. Providers vs. Patients: Ethical Dilemmas in Public Health
   - Bioethicists and the Evolution of Death

5. Case in Microethics: Is it OK to Hug Patients?

6. How to Support a Colleague Who’s Impaired or Incompetent at Work
   - Sharing Health Data via Mass Hiway

7. Member News and Notes
   - Across the Commonwealth

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Thursday, May 17, 2018

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