

# VITAL SIGNS



MASSACHUSETTS  
MEDICAL SOCIETY

*Every physician matters,  
each patient counts.*



VOLUME 21, ISSUE 8, OCTOBER 2016

## Coalition Unites Against Recreational Marijuana

BY VICKI RITTERBAND  
VITAL SIGNS CONTRIBUTING WRITER

Bob Doyle, chair of Better Way Colorado, a nonprofit coalition opposed to marijuana legalization and commercialization, observes what's happening in Massachusetts and, for him, it's déjà vu. In November, residents will decide whether recreational marijuana should be legalized here, a question Colorado voters answered a resounding "yes" to four years ago.

"The arguments the pro-marijuana proponents are making in Massachusetts are a repeat of those we heard in Colorado," Doyle said. "They claim this is about rights and social justice but it's not. It's about the mass commercialization of marijuana — marijuana soda, vaping devices, gummy drops, cupcakes, and the high potency extracts."

If Question 4, "Legalization, Regulation, and Taxation of

Marijuana," passes on November 8, Massachusetts residents 21 and older could possess up to one ounce of marijuana for recreational use. Buyers would pay a 3.75 percent excise tax on top of the state's 6.25 percent sales tax. Retail sales could begin in January 2018 and marijuana would be sold in many forms, including foods and drinks.

Doyle said that there are several big differences between his state's anti-legalization campaign four years ago and Massachusetts' today, beginning with the fact that Colorado was unable to launch a state-wide grass roots campaign. By contrast, here, opponents to the measure have marshaled a diverse coalition of stakeholders under the umbrella of the Campaign for a Safe and Healthy Massachusetts ([www.safeandhealthyma.com](http://www.safeandhealthyma.com)). Members include the MMS, the Massachusetts Hospital Association (MHA), the Massachusetts Chiefs

of Police Association, the Massachusetts Association of School Superintendents (MASS), and public officials such as Governor Charlie Baker, Boston Mayor Marty Walsh, and Attorney General Maura Healey.

"The medical voice is very influential with voters," Doyle said, "because it's a critical public health and safety issue."

### Medical Society's Efforts

For nearly two decades, the MMS has had a formal policy opposing the legalization of recreational marijuana. Recently, in the face of the ballot initiative, its leadership has reiterated its opposition — for reasons that range from the drug's addictive nature to its adverse effects on developing brains to the appeal of edibles — specifically those packaged to look like candy or other sweet treats — to youngsters. MMS President James Gessner, M.D., said it's the Society's number one issue this fall.

The MMS has developed and distributed brochures for physicians' offices that outline its arguments against legalization, and is writing and speaking out about the issue in various venues. Additionally, the MMS has a page on its website dedicated to Question 4. "The campaign will be short and intense," Dr. Gessner said, "and an important part of it will be encouraging our physicians to talk to their patients about the health implications of legalization."

### Health and Safety Arguments

The MMS is joined in opposition to the ballot question by other health care stakeholders, including the MHA, the Massachusetts chapter of the National Alliance on Mental Illness (NAMI), and the Association for Behavioral Healthcare. Like the Medical Society, NAMI is particularly concerned about the effects of marijuana on developing brains.

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## MassPAT's Upgrades: Ease of Use

BY ROBERT ISRAEL  
VITAL SIGNS EDITOR

In advance of the August 22 debut of MassPAT, the state's prescription monitoring program, the DPH invited Alain A. Chaoui, M.D., MMS vice president, to join a group of physicians to test the enhanced interactive tool. The DPH, working cooperatively with the MMS, had previously hosted several "tryouts" during the year to ensure MassPAT's \$6 million system upgrade performed as promised before they rolled it out to more than 46,000 prescribers.

"I was pleasantly surprised at what I discovered," Dr. Chaoui



Alain A. Chaoui,  
M.D.

reported. "It took less than three minutes to register online. In the past, I had to spend numerous clicks of my computer's mouse to get up and running. All that has changed with the new system."

### A More Complete Patient Profile

Ease of access is not the only feature Dr. Chouï noted about MassPAT.

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## State Legislative Roundup

BY RONNA WALLACE  
MMS LEGISLATIVE CONSULTANT

The legislative session that ended July 31 saw the passage of new laws relevant to physicians and their patients. Here is a roundup of bills passed at the end of the session as either part of the 2017 state budget or individually:

- "Act Relative to Equitable Health Care Pricing" (Chapter 115) establishes a commission to review price variations among health care providers.
- "Act Relative to the Massachusetts Child Psychiatry Access

Program" (Chapter 160) requires the Department of Public Health to implement a state-wide program to provide remote mental health consultations at least five days a week to pediatricians and other practitioners for persons under the age of 19 with a possible mental health or substance use disorder. Funded by an assessment on private health insurers, it passed with an emergency preamble, making it effective July 1, 2016.

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**2016 Interim Meeting —  
see page 6.**



## The Need for Physician Wellness

In my previous President's Message, I emphasized our advocacy in two areas: the opioid crisis, and specifically, the state's new prescription monitoring program, MassPAT, and the upcoming ballot question on recreational marijuana.

The opioid epidemic and opposition to recreational marijuana will continue as priorities of our Society; these are critical public health issues for the Commonwealth.

Another major issue is before us, however, and its implications can be just as serious: physician burnout.

Our profession is quickly recognizing that burnout is a crisis. A Mayo Clinic study discovered that more than 54 percent of physicians are experiencing burnout. Increasing workloads, burgeoning administrative requirements, rapid and widespread changes in health care, and lack of control and autonomy are all taking their toll.

Such a trend has consequences. Professionally, it can result in more medical errors, worse patient outcomes, disruptive behavior, and decreased productivity. Personally, it can lead to higher rates of divorce, depression, anxiety, and substance abuse.

Patients can suffer as well from those errors and poor outcomes, and deteriorating patient-physician relationships. U.S. Surgeon General Vivek Murthy, M.D., has acknowledged and captured the essence of the problem: "If health care providers aren't well," he said, "it's hard for them to heal the people for whom they are they caring."

The MMS will be examining this topic in the months ahead. It is, after all, part of our mission: to address the needs of physicians and preserve their ability to care for their patients.

— James S. Gessner, M.D.

## Recreational Marijuana

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"The research shows that marijuana poses a risk for the young brain — those 25 and under — that is predisposed to emotional and mental health issues," said NAMI Mass Executive Director Laurie Martinelli. Marijuana also could interfere with medication adherence. Furthermore, because mental illness and substance use disorders often go hand-in-hand, it's likely the incidence of dual diagnoses will increase once marijuana is legalized, according to Martinelli.

The MHA is opposing the ballot question for many reasons, but they fall into several categories, according to President and CEO Lynn Nicholas: the health and safety effects of regular use, the capacity of hospitals and particularly emergency departments to handle an uptick in drug-related health problems and emergencies, and the financial implications for a health care system that is struggling to keep costs down.

"Also, we don't have adequate substance use facilities in the state now for those who are addicted to alcohol and opioids," Nicholas said. "You add this and it's like breaking the camel's back." She added that the MHA is concerned about the effect of legalization on health care workers. "If this becomes more available, how do you ensure that health care workers are not coming to work under the influence? It's hard to monitor marijuana use."

## More Coalition Voices

Associated Industries of Massachusetts (AIM), the largest employer association in the state and another member of the Campaign for a Safe and Healthy

Massachusetts, shares the MHA's workforce concerns. "Many of our members are employers in safety-sensitive areas like manufacturing and transportation and they do drug testing," explained AIM President and CEO Rick Lord. "Even if you're using legally in your home, you won't pass the drug test. So what will be the implications for companies that are struggling to hire workers?" AIM also opposes the initiative because some companies may lose their favorable workers' compensation insurance rates because they will no longer be drug-free workplaces, according to Lord.

The Massachusetts Chiefs of Police Association has come out strongly against marijuana legalization. Spokesman John Carmichael, the police chief in Walpole, said his group believes that if Question 4 passes, the state will see an increase in impaired driving and motor vehicle accidents. He pointed out, most police officers do not have the training to accurately assess impairment. And if drivers are suspected of operating while under the influence of marijuana, they can refuse to submit to drug screening without consequence. That's not true with alcohol, where refusing a breathalyzer will result in a 180-day license suspension.

"If you look at Colorado, 77 percent of their OUIs [in the first half of 2014] involved drivers who used marijuana, and fatal crashes have gone up," Carmichael said. "If we do legalize marijuana, we're going to have to train over a million officers in field sobriety tests for marijuana."

Carmichael believes the argument that legalizing marijuana will free up the police to go after "real" crime is a "ridiculous" one.

"If someone is arrested because they have drugs on them, it's very rarely because of just the drugs. Usually the drug arrest is incidental to something else — drunk driving, a revoked license, or a probation violation," he explained.

Meanwhile, the MASS also has numerous concerns about marijuana legalization. "We already have our hands full, trying to work with our kids and communities around alcohol issues," said Tom Scott, executive director of the MASS.

## Coalition of Opponents

Corey Welford, spokesperson for the Campaign for a Safe and Healthy Massachusetts, said while he expects that the pro-ballot question activists will receive a substantial influx of marijuana industry money to support their efforts, they are at a disadvantage for one critical reason: "They can't match us in terms of the breadth of our coalition." Welford, who is attorney general Maura Healey's former chief of staff, added, "We are a grassroots network and we will be opposing this in communities in every part of the state."

The Campaign will be participating in debates, community events, and press conferences and doing as much media outreach as possible, including writing op-eds and letters to the editor as well as requesting editorial board meetings. Opponents are optimistic about their chances of defeating the initiative. "Our strongest strategy is to get as much information as we can in front of the widest audience possible," Welford said. "The more people learn about the implications of the ballot question, the more concerns they will have."

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## LAW AND ETHICS

## Clarifying the Right to Access Health Information

BY LIZ ROVER BAILEY  
MMS ASSOCIATE COUNSEL

In early 2016, the Federal Government released official guidance on an individual's right to access health information. Referred to as the "Guidance," it did not establish new requirements but instead clarified areas of confusion, especially in light of the increased use of electronic health records. It remains true that a HIPAA-covered entity must provide an individual with access to their protected health information (PHI) in one or more "designated record sets." This includes any information used to make decisions about the individual, such as billing records, medical images, wellness and disease management, and clinical case notes, whether or not such records are part of an electronic health record or the individual's medical record. The Guidance clarified issues around the method of access, the way in which it

is requested, fees the covered entity may charge, and potential reasons to deny access.

Key points include the following:

**Method of Access.** A covered entity must provide the PHI in the form and format requested if it is readily available in that format, or in a readable hard-copy form, or another agreed-upon form. If the individual requests an electronic version, and it is available in that format, it must be provided electronically. The covered entity must mail the PHI, or arrange a convenient time and location for the individual to pick it up.

**Requesting Access.** The covered entity must verify the individual's identity, but may not create barriers to, or unreasonably delay, the individual's access to the PHI. The Guidance suggests that requiring a person to make the request by visiting the office, using a web portal, sending it by mail are all

unreasonable measures that create barriers or delay access.

**Fees.** A covered entity may charge, *at most*, the cost of (a) labor for copying the PHI (but not a search-and-retrieval cost), (b) the supplies used to create the copy or electronic media, (c) postage if the recipient has requested that the information be mailed, and (d) preparation of a summary if the individual requested one and agreed to pay the fee. A covered entity may not charge a fee if the request is made for the sole purpose of supporting a claim under any federal or state financial-needs-based benefit program. If a fee is to be charged, the entity must inform the individual in advance of the approximate amount of the fee.

**Denial of Access.** Only under rare circumstances may a covered entity deny an individual's access to his or her health information.

Before denying access, a covered entity should consult an attorney or other professional to be sure such denial is allowed. A covered entity may not deny access to records based on the reason for which they are requested, or because a business associate of the entity (rather than the entity itself) maintains the records. Further, covered entities may not withhold records from a patient with unpaid bills, but may require payment for the records before providing them to the individual.

In light of this recent Guidance, covered entities should periodically make sure they conform to the HIPAA compliance practices as interpreted and enforced by the federal government.

The "Law and Ethics" column is provided for educational purposes and should not be construed as legal advice. Readers with specific legal questions should consult with a private attorney.

## Improve Patient Access with Strategic Scheduling Practices

BY ALEXIS KLYM  
PPRC SPECIALIST

Establishing effective scheduling protocols to efficiently manage patient panels is a difficult task for physician practices because it requires balancing clinical obligations, patient needs and practice resources. However, implementing strategic scheduling

practices, such as same-day appointments, in provider schedules can enhance the patient experience by improving access to timely care. Physician practices should consider piloting various scheduling models to optimize access and implement policies that demonstrate the following sentiments:

- **To Retain Established Patients and Obtain New Patients:** The longer patients wait to see a physician, the more likely they are to cancel or seek care elsewhere.
- **To Demonstrate Practice Values:** Implementing strategies to manage patients based on level of urgency exhibits that a practice values safety, timeliness, and patient-centeredness.
- **To Avoid Revenue Loss:** Providers miss opportunities to engage with patients when appointments are missed. Practices should discuss with their practice management software vendor whether the following are functions available within the scheduling system. If so, adopting the following scheduling tools and approaches can enhance patient access and the patient experience:
  - **Flagging High-Risk No-Shows:** New data analysis tools examine patients' attendance history to label patients as high-risk for cancellations or no-shows. Practices can make additional efforts to reach out and remind these high-risk patients of their appointments, decreasingly the likelihood of a no-show.
  - **Auto-rescheduling:** Auto-scheduling allows practices to attempt to fill appointments that are cancelled within 48 hours by sending automated text messages or emails to patients who have previously failed to show and do not have a future appointment scheduled or are on the waiting list.
  - **Open-Access Scheduling:** Open-access scheduling allows patients to schedule appointments online by viewing a calendar of available times. Some tools offer appointment


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## Climate Change: Are We at Risk?

BY ROBYN ALIE  
HEALTH POLICY AND PUBLIC HEALTH  
MANAGER



Ira Helfand,  
M.D.

This year's record high temperatures are expected to increasingly cause adverse health and public health effects, such as

extreme weather events, vector and waterborne diseases, drought, and malnutrition.

Scientists warn such effects of climate change will intensify political conflict and increase the threat of nuclear war. They point to the case of Syria, where extreme multiyear drought beginning in 2006 compromised the livelihood of farming families and others, who migrated *en masse* to cities. The mass migration led to overcrowding, unemployment, and poverty, likely fueling more civilian unrest. Civil war broke out in 2012, and more than 250,000 have died while millions more have fled the country.

"As climate change progresses, we will see further conflict, and the very real possibility that this conflict will involve the use of nuclear weapons," said Ira Helfand, M.D., an emergency physician, and copresident of International Physicians for the Prevention of

Nuclear War (IPPNW). IPPNW was awarded a Nobel Peace Prize for its efforts to promote awareness of the catastrophic consequences of nuclear warfare in 1985. The International Campaign to Abolish Nuclear Weapons puts the number of warheads at more than 15,000 held by nine countries around the globe, including the U.S., Russia, the U.K., France, China, India, Pakistan, Israel, and North Korea.

Even a limited nuclear war would cause the death of millions of people, said Dr. Helfand, who authored *Nuclear Famine: Two Billion People at Risk*. The 2013 report analyzed the global agricultural disruption a small scale, regional nuclear war would likely cause, leading to significant crop reductions in the U.S. and around the globe, increases in food prices, food insecurity, malnourishment, and starvation.

### Symposium: October 15

Climate change and nuclear war will be explored from a health care perspective by Dr. Helfand and other leading experts at a symposium on October 15, hosted by the Greater Boston Physicians for Social Responsibility, cosponsored by MMS, the Boston area medical schools, and others.

For more information, visit [www.psr.org/symposium](http://www.psr.org/symposium).

## Mouthguards Prevent Sports Injury

BY MICHELLE DALAL, M.D.  
MMS COMMITTEE ON ORAL HEALTH

The increase in sports activities and their competitiveness have led to new challenges, including an increase in orofacial injuries during contact sports. More than five million teeth are avulsed each year, many during sports activities, resulting in nearly \$500 million spent on replacing these teeth. During a single athletic season, athletes have a 1 in 10 chance of suffering a facial or dental injury, according to research published in the *Journal of the American Dental Association*.

These painful injuries can lead to difficulties eating and talking and contribute to negative self-esteem issues that arise from the appearance of damaged teeth. Furthermore, they may require costly restorative, endodontic, or surgical treatments over a long period of time.

Mouthguard use prevents over 200,000 orofacial injuries per year in high school and college football athletes, according to research published in the *Journal of Clinical and Diagnostic Research*.

In Massachusetts, mouthguards are mandated for all athletes participating in football, field hockey, ice hockey, soccer, lacrosse, and wrestling. The MMS and the Massachusetts Dental

Society (MDS), strongly recommend mouthguards for athletes playing any sport where there is a risk of injury to the mouth, such as basketball, baseball, soccer, field hockey, and volleyball.

Medical providers and dental providers should encourage routine mouthguard use for injury prevention at annual health maintenance visits. Although over-the-counter mouthguards may be used, custom-fit mouthguards made by dentists usually fit the best. Mouthguards should be comfortable, durable, and easy to clean, and they should not restrict breathing or speech.

The MMS encourages mouthguard use in all contact and collision sports, particularly in children and adolescents. The MMS's Committees on Oral Health and Student Health and Sports Medicine and the MDS have collaborated to develop educational materials designed for families, schools, and coaches. These include the "Grin and Wear It" brochure and a poster providing facts about preventable orofacial injuries and describe types of available mouthguards and how to care for them.

You can download them at [www.massdental.org/mouthguards](http://www.massdental.org/mouthguards).

### MassPAT's Upgrades

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"In my practice, I rely on the work of several medical assistants," he said. "MassPAT enables these assistants to register as delegates so long as they indicate they are working with me as the prescriber. Together we can review a patient's prescribing history and ensure our patients are receiving — and using — the appropriate medications."

Dr. Chouli found that MassPAT provides a more complete patient profile. "When used in concert with a patient's electronic health records," he said, "MassPAT is a very useful tool, indeed."

### Other New Features

MassPAT's tracking functionality encourages appropriate

prescribing. It reports if a patient is visiting other physicians' offices and it provides a comprehensive list of the medications they are authorized to take. Furthermore, the online tool tells the prescriber if the patient is paying for the medication via an insurance plan, or using cash. By warning the prescriber about the existence of dual scripts, MassPAT discourages "doctor shopping" by individuals who may be attempting to build up a cache of opioid medications.

"I also find it helpful that MassPAT allows access to prescribing information from neighboring states such as Vermont, Rhode Island, and Connecticut," Dr. Chaoui added. "In the coming weeks, that list will expand to include New York,

New Hampshire, and Maine. Taken as a whole, the data that MassPAT provides is crucial to my work, because it ensures patient safety."

### Importance of Registering

MMS President James Gessner, M.D., emphasized the importance of all prescribers to register for MassPAT, declaring that the tool "improves care, decreases the number of prescriptions that may be out there, and tightens the system appropriately."

The new tool, along with increased efforts in prescriber education about opioids and pain management, should further help to reduce the number of prescriptions being written. The MMS's educational efforts have reached nearly 6,000

prescribers and, along with the monitoring program, have contributed to a reduction in overall prescriptions. In Massachusetts, according to data published in July by athenahealth, the numbers of opioid prescriptions fell by 25 percent over an 18-month interval, representing a steeper decline than the national average, which indicated a 13 percent reduction. Data compiled by the DPH further showed that the total number of opioid Schedule II prescriptions and the number of individuals receiving Schedule II prescriptions were both at their lowest levels since the first quarter of 2015. Additionally, the number of individuals who received one or more prescriptions for opioids dropped 16 percent

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# Congress, the White House, and Opioid Abuse Prevention

BY ALEX CALCAGNO, MMS DIRECTOR OF FEDERAL AND COMMUNITY RELATIONS

Before adjourning for the summer, Congress passed the Comprehensive Addiction and Recovery Act (CARA). It was signed into law by President Obama on July 22, 2016. Although the law is being hailed as one of the federal government's major actions to combat opioid abuse in years, significant concerns remain over its failure to include any funding to implement new programs. Members of the Massachusetts Congressional delegation led much of the advocacy in support of provisions to combat opioid abuse, as well as supporting efforts — that were later dashed — to appropriately fund the new law.

The CARA authorizes a number of new programs. These include the following:

- Establishing new prevention and educational efforts — particularly aimed at teens, parents and other caretakers, and aging populations — designed to stem the abuse of

methamphetamines, opioids, and heroin, and to promote treatment and recovery

- Expanding the availability of naloxone to law enforcement agencies and other first responders to help in the reversal of overdoses to save lives
- Expanding efforts to identify and treat incarcerated individuals suffering from addiction disorders promptly by collaborating with criminal justice stakeholders and by providing evidence-based treatment
- Expanding disposal sites for unwanted prescription medications to keep them out of the hands of children and adolescents
- Establishing a new evidence-based opioid and heroin treatment and intervention program to expand best practices throughout the country
- Strengthening the medication assisted treatment and intervention demonstration program

- Strengthening prescription drug monitoring programs to help states monitor and track prescription drug diversion and to help at-risk individuals access services

Additionally, the CARA includes the “Reducing Unused Medications Act,” the so called “partial-fill legislation,” introduced and championed by Sen. Elizabeth Warren (D-MA) and U.S. Rep. Katherine Clark (D-MA). The MMS initiated the concept of partial-fill in Massachusetts and strongly supported its passage at the federal level. Partial-fill prescriptions can help patients balance the need to relieve pain with an adequate supply of medication by only filling a portion of the prescription. Partial-fill prescriptions can also help to cut drug diversion — something that makes up a significant part of the opioid abuse crisis. Estimates from the National Institute on Drug Abuse indicate that the majority of individuals (up to 70 percent) who misuse or abuse pain medications get them

from prescriptions written for someone else, such as friends or family. Prior to the federal legislation, DEA regulations prohibited partial-fill in other than in very limited circumstances.

Immediately before passage of the CARA, the Administration issued final rules increasing the number of patients qualified physicians can treat with buprenorphine from 100 to 275. The provision went into effect on August 8, 2016. Efforts to increase the number of patients that could be treated with buprenorphine were led by Sen. Edward Markey who introduced the Recovery Enhancement for Addiction Treatment (TREAT) act, supported by the MMS and AMA, which would have achieved a similar goal. The administration's regulation expedited the process and eliminated the need for additional Congressional funds, which were not forthcoming. The MMS will be providing educational programs to help train and inform physicians interested in treating the maximum number of patients under these new regulations.

## State's Legislative Session

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- “Act Relative to Long-term Antibiotic Therapy for the Treatment of Lyme Disease” (Chapter 183) requires private health insurers to cover the costs of long-term antibiotic therapies and off-label uses of other drugs to treat Lyme disease when deemed medically necessary by a treating physician.
- “Act Relative to HIV-Associated Lipodystrophy Syndrome Treatment” (Chapter 233) requires MassHealth and private insurers to cover medical or drug treatments related to HIV-associated lipodystrophy syndrome, a side effect of drugs that were used to treat HIV in the early 1990s.
- “Acts to Increase Access to Immunizations” (Chapter 234) allows certified medical assistants to administer immunizations under the direct supervision of a licensed primary care provider.

- An Act Relative to Equitable Health Care Pricing,” (Chapter 115), created a Special Commission on Provider Price Variation. It was passed as part of a deal reached in May to avoid a controversial ballot question that would have reduced health insurance payments to the state's largest hospital network, Partners HealthCare, and increased payments to lower paid competitors.

Bills that failed in this legislative session that will likely be reintroduced in the next session include an act to remove the restrictions on licenses of nurse practitioners and certified registered nurse anesthetists. The MMS will be active this fall monitoring informal sessions and building our 2017–2018 legislative agenda.

## MMS eCommunities Is Now



BY LEON BARZIN  
MMS HIT DIRECTOR

On September 7, the MMS eCommunities member collaboration website was given a new look, thanks to an internal upgrade and design. If you participate in an MMS committee, task force, or district leadership role, you have probably discovered how useful the eCommunities website has been for posting articles and documents and discussing ideas with other like-minded members.

This private online discussion area allows groups to post messages and documents that are distributed automatically to all the members of the group, as are any replies. It's a great way to popularize initiatives, review

draft resolutions, or discuss pertinent issues.

MMS Connect is the new name and it is sporting a more modern and colorful look. It retains the same helpful features plus one new one. As of September, a MMS Event Manager was added to streamline the process of organizing regular MMS meetings. The Event Manager allows staff to alert members to upcoming meetings while providing one-click RSVP for members that are communicated back privately to the liaison.

You can log into the new MMS Connect site from the bottom of any [www.massmed.org](http://www.massmed.org) page with your username and password.

## Sick Physicians: What's Changed in 50 Years?

BY STEVEN ADELMAN, M.D.  
PHS DIRECTOR

In a 1966 *Medical World News* article, "What It's Like to Be a Doctor Addict," the anonymous author declared, "the most enlightened medical profession that civilization has ever known, in the wealthiest country in history, doesn't know how to treat me." What's changed in the ensuing 50 years?

A review of the physician health movement helps us to answer this question. In 1973, the AMA's Council on Mental Health published a landmark article in *JAMA*: "The Sick Physician — Impairment by Psychiatric Disorders, Including Alcoholism and Drug Dependence." The article cited medical board data from three states suggesting that approximately 5 percent of physicians were subject to board actions due to psychiatric and substance use disorders. Physician impairment was, in fact, the main cause of disciplinary actions.

The council called on state medical societies to create committees to specifically focus on physician impairment; it also advised state medical boards to adopt enlightened "sick physician statutes" that would balance concerns about patient safety with interest in the welfare and well-being of physicians. These statutes were intended to incent physicians with significant health challenges to get out of harm's way in a nonpunitive fashion, get better, and whenever possible,

return to work with safeguards that support both patient safety and physician health.

The MMS launched its Impaired Physicians Committee in 1978. Two of its founding fathers, Drs. Edward Khantzian and Aaron Leavitt, recently stepped down from PHS's board after more than 35 years of loyal service. Around 1990, the committee was renamed the Physician Health Committee; three years later, the MMS created a separate nonprofit subsidiary: Physician Health Services (PHS). Within a decade, PHS earned a reputation as one of the country's best and most-enlightened state physician health programs.

These days, physician health programs like PHS now possess a great deal of experience and expertise when it comes to assisting physicians and medical students. Some doctors with alcohol and/or drug problems refer themselves. Unfortunately, some physicians who need help wait too long and end up being referred to PHS by a colleague, an attorney, a treating physician, a medical leader, or the Board of Registration in Medicine (BRM).

When "doctor addicts" come to PHS, we assess the situation and direct the physician to the appropriate level of care. Sometimes short-term intensive outpatient treatment is recommended to jump-start a physician into recovery. In other cases, physicians suffering from moderate to severe substance use disorders that have caused significant collateral

damage do best in a health professionals' rehabilitation program, where they engage in a recovery process with other doctors and are treated by a staff trained in the unique challenges faced by physicians in recovery. Fifty years later, there is a range of specialized treatment options available for physicians with substance use disorders.

Since the milestone 1973 *JAMA* article on "sick physicians," the scope of problems addressed at PHS has become much broader. Behavioral problems in the areas of professionalism, communication, and disorganization are behind many PHS referrals. Many physicians are referring themselves for help with stress, professional burnout, and work-life imbalance.

Fifty years ago, a physician with a history of drug addiction didn't know where to find treatment. These days, it is incumbent upon us to support excellent patient care by creating a humane work environment that promotes the occupational health of physicians and other professionals.

### IN MEMORIAM

The following deaths of MMS members were recently reported to the Society. We also note member deaths on the MMS website, at [www.massmed.org/memoriam](http://www.massmed.org/memoriam).

**Gaston E. Blom, M.D.**, 96, Brookline, MA; Harvard Medical School, Boston, 1944; died April 20, 2016.

**Allan D. Callow, M.D.**, 99, San Francisco, CA; Harvard Medical School, Boston, 1942; died December 22, 2015.

**Franklyn H. Carrington, M.D.**, 71, Agawam, MA; Temple University School of Medicine, Philadelphia, 1970; died July 23, 2016.

**Mayo Johnson, M.D.**, 84, Beverly, MA; Columbia University College of Physicians and Surgeons, 1957; died August 24, 2016.

**Jacob Matloff, M.D.**, 96, Dedham, MA; Boston University School of Medicine, Boston, 1943; died May 29, 2016.

**Wladyslaw J. Mitus, M.D.**, 87, Altadena, CA; Faculty of Medicine, University of Edinburgh, 1946; died September 20, 2007.

**Philip G. Sullivan, M.D.**, 83, Monument Beach, MA; Tufts University School of Medicine, Boston, 1958; died June 23, 2016.

## Martin Appointed at Countway

Elaine Martin has been appointed director, head librarian, and chief administrative officer of the Francis A. Countway Library of Medicine. She previously worked as director of library services at the Lamar Soutter Library at UMass Medical School, Worcester. She will oversee Countway's \$7.3 million budget and



Elaine Martin

collections of more than 630,000 volumes of current medical research materials and historical and rare collections. The Countway serves academic and practicing physicians at Harvard's Medical School, Chan School of Public Health, School of Dental Medicine, as well as the Boston Medical Library and the Massachusetts Medical Society.

## 2016 Interim Meeting of the MMS House of Delegates

Friday and Saturday, December 2–3, 2016  
MMS Headquarters and the Westin Hotel, Waltham



- Online registration is open at [massmed.org/interim2016/register](http://massmed.org/interim2016/register). Plan to attend a Town Hall Meeting with the Presidential Officers, Annual Oration, Bi-annual Ethics Forum, and Annual Research Poster Symposium, which offers a venue for residents, fellows, and medical students to display original research.
- Submit your resolutions at [massmed.org/resolutions](http://massmed.org/resolutions) by October 18.
- Hotel deadline is November 4. Please visit [massmed.org/IM16reservations](http://massmed.org/IM16reservations) or call the hotel at (781) 290-5600.

**MassPAT's Upgrades**

*continued from page 4*

from the first quarter of 2015 to the second quarter of 2016.

“We applaud the MMS for working closely with state leaders to ensure MassPAT has the tools physicians need to help address the opioid crisis,” said AMA President Andrew W. Gurman, M.D. “This partnership between physician leaders and policymakers builds on progress that already has resulted in a shrinking number of prescriptions being issued in the Bay State. Signing up for the new program — and learning to fully use the tool to make more informed prescribing practices — is a critical step each physician can take to fight this scourge.”

**New CME Course**

Yet MassPAT alone cannot ensure that the decline in numbers of prescriptions will continue apace. Only when the prescription monitoring tool used in tandem with an ongoing educational effort — so that all prescribers are taking

advantage of its multiple functionalities — will the opioid menace be further contained.

Toward that end, the MMS is encouraging prescribers to register, free of charge and for continuing medical education credit, in an online course designed to explain MassPAT's enhanced capabilities. The course is designed to help prescribers access and use the new features to provide better care for their patients. Like the early testing of MassPAT that led to its ultimate rollout, the course is being co-taught with the DPH.

The course covers basic enrollment and navigation of the new MassPAT website, explores changing legal requirements, offers tips for how to incorporate the tool into clinical practice, and presents information on how to best utilize the data to enhance prescribing and patient care.

To register online, visit [massmed.org/continuingeducationandevents](http://massmed.org/continuingeducationandevents).

**Smart Scheduling**

*continued from page 3*

windows based on appointment classification (annual check-ups versus surgeries) or patient classification (new patients versus established patients).

• **Online Patient Portals:**

Portals allow patients to be more involved in their health-care, which may encourage preventative actions that potentially reduce unnecessary visits.

• **Patient Contact Centers:**

Establishing a centralized patient contact center allows practices to discuss scheduling, pre-registration, insurance verification, and out-of-pocket costs with patients before

appointments, reducing confusion for both patients and practice staff.

• **Confronting Access Issues:**

Practices should be able to appropriately address access to care. Potential access barriers may include a shortage of rooms, physicians, medical assistants, or other administrative resources. Ways of improving availability are by offering alternatives to communicate with providers such as email, patient portal access, or telemedicine services.



**Link In with MMS**

Connect with your peers by joining our members-only LinkedIn group at [www.massmed.org/linkedin](http://www.massmed.org/linkedin).

**ACROSS THE COMMONWEALTH**

**District News and Events**

**NORTHEAST REGION**

**Charles River — Delegates Meeting.** Tues., Oct. 13, 6:30 p.m. Location: MMS Headquarters, Waltham.

**Middlesex Central — Delegates Meeting.** Thurs., Oct. 20, 7:45 a.m. Location: Emerson Hospital, Concord.

**Middlesex West — District Meeting.** Tues., Oct. 25, 6:00 p.m. Location: Marlborough Country Club, Marlborough. Guest Speaker: Alex Calcagno, Director of Advocacy and Federal and Community Relations.

**Norfolk — Fall District Meeting.** Wed., Oct. 5, 6:00 p.m. Location: Sheraton, Needham Hotel, Needham. Speaker: George P. Santos, M.D. Topic: Medicinal Plans in Literature Art, History, and Geopolitics.

**Suffolk — Fall District Meeting.** Thurs., Oct. 20, 6:00 p.m. Location: Downtown Harvard Club, Boston. Speaker: Gail Gazelle, M.D., F.A.C.P., F.A.A.H.P.M. Topic: Building Your Resilience Self™: Strategies to Move from Burnout to Well-Being.

For more information to contribute news, please contact Michele Jussaume or Linda Howard, Northeast Regional Office at (800) 944-5562 or [mjussaume@mms.org](mailto:mjussaume@mms.org) or [lhoward@mms.org](mailto:lhoward@mms.org).

**SOUTHEAST REGION**

**Bristol South — District Meeting.** Fri. Oct. 28, 6:00 p.m. Location: New Bedford Whaling Museum, New Bedford, MA. Reception followed by optional tours, dinner and musical entertainment.

For more information, or if you have Southeast District news to contribute, please contact Sheila Kozlowski, Southeast Regional Office at (800) 322-3301 or [skozlowski@mms.org](mailto:skozlowski@mms.org)

**WEST CENTRAL REGION**

**Hampden — Executive Board Meeting.** Tues., Oct. 18, 6:00 p.m. Location: HDMS Office, West Springfield. **Fall District Meeting.** Tues., Oct. 25, 6:30 p.m. Location: Delaney House, Holyoke. Speaker: Alfred DeMaria Jr., M.D. Title: The Challenge of Zika: From the Wild to the Prenatal Clinic.

**Hampshire/Franklin — Fall District Meeting.** Wed., Oct. 26, 6:00 p.m. Location: Lord Jeffrey Inn, Amherst. Speaker: Senate President Stan Rosenberg. Topic: Remarks from Senate President Rosenberg.

**Worcester — 11th Annual Louis A. Cottle Lecture.** Mon., Oct. 17, 5:30 p.m. Location: Beechwood Hotel, Worcester. Speaker: Diane W. Shannon, M.D., MPH, Former practicing physician and medical freelance writer. Topic: Physician Burnout: An Under-recognized Problem.

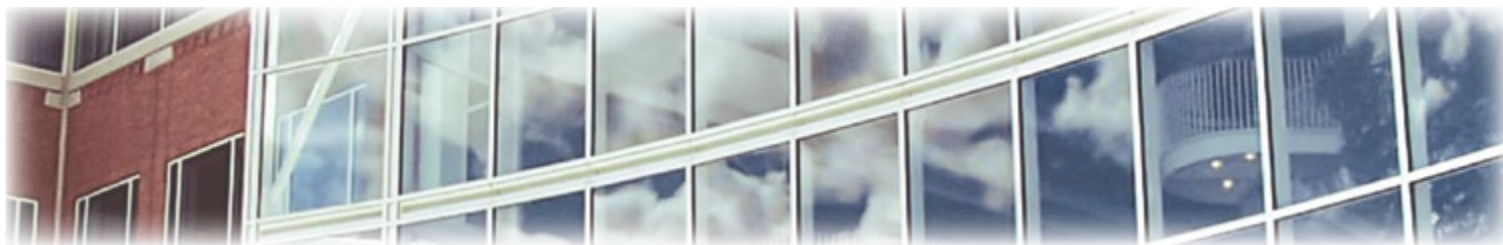
**Worcester North — Fall District Meeting.** Thurs., Oct. 27, 6:00 p.m. Location: Fay Club, Fitchburg. Speaker: Mario Motta, M.D.

For more information to contribute news, please contact Cathy Salas, West Central Regional Office at (800) 522-3112 or [csalas@mms.org](mailto:csalas@mms.org)

**Statewide News and Events**

**Arts, Humanism, History, and Culture Member Interest Network — Introduction to Birding.** Lecture: Thurs., Sept. 29, 6:30–8:00 p.m. Field Trip: Sat., Oct. 1, 9:30–11:00 a.m. Location: Lecture, MMS Headquarters, Waltham. Field Trip, Joppa Flats, Newburyport. At the lecture a variety of birds will be reviewed with many aids and at the field trip, we will explore the salt marshes, maritime forests, and large freshwater impoundments looking for a wide variety of birds.

For more information to contribute news, please contact Cathy Salas, West Central Regional Office at (800) 522-3112 or [csalas@mms.org](mailto:csalas@mms.org)



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MASSACHUSETTS  
MEDICAL SOCIETY

# VITALSIGNS

VOLUME 21, ISSUE 8, OCTOBER 2016

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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/](http://www.massmed.org/cme/) events.

**Evolutionary Biology in Clinical Medicine Webinar**  
Monday, September 19, 2016, *Via Live Webinar*

**Building Leadership Skills: What's in Your Toolbox?**  
Friday, September 30, 2016

**Managing Workplace Conflict**  
Thursday, November 3, and Friday, November 4, 2016

### ONLINE CME ACTIVITIES

Visit [www.massmed.org/cme/](http://www.massmed.org/cme/)  
**Risk Management CME**

#### Electronic Health Records Education (3 modules)

- Module 1 — EHR Best Practices, Checklists, and Pitfalls
- Module 2 — Making Meaningful Use Meaningful: Stage 1

- Module 3 — Making Meaningful Use Meaningful: Stage 2

#### End-of-Life Care

- End-of-Life Care (3 modules)
- The Importance of Discussing End-of-Life Care with Patients
- Advance Directives (*Legal Advisor*)
- Principles of Palliative Care and Persistent Pain Management (3 modules)

#### Pain Management and Opioid Prescribing

- Managing Pain Without Overusing Opioids
- The Opioid Epidemic: Policy and Public Health (6 modules)
- Principles of Palliative Care and Persistent Pain Management (2 modules)
- Opioid Prescribing Guidelines in Practice
- Opioid Prescribing Series (6 modules)
- Identifying Potential Drug Dependence and Preventing Abuse (*Legal Advisor*)
- Managing Risk when Prescribing Narcotic Painkillers for Patients (*Legal Advisor*)

#### Medical Marijuana (4 modules)

- Module 1 — Medical Marijuana: An Evidence-Based Assessment of Efficacy and Harms
- Module 2 — Medical Marijuana in the Commonwealth: What a Physician Needs to Know
- Module 3 — Medical Marijuana in Oncology
- Module 4 — Dazed and Confused: Medical Marijuana and the Developing Adolescent Brain

#### Additional Risk Management CME Courses

- Initiating a Conversation with Patients on Gun Safety
- Bullies and Victims: Can You Tell the Difference?
- Intimate Partner Violence: The Clinician's Guide to Identification, Assessment, Intervention, and Prevention
- Understanding Clinical Documentation Requirements for ICD-10
- ICD-10: Beyond Implementation
- Prostate Cancer and Primary Care
- Cancer Screening Guidelines (3 modules)
- HIPAA 2.0: What's New in the New Rules?
- Impact of Effective Communication on Patients, Colleagues, and Metrics (2 modules)
- Effective Chart Review for Quality Improvement

#### Additional CME Courses

- Carbon Monoxide Poisoning
- Genetically Modified Foods: Benefits and Risks
- Just a Spoonful of Medicine Helps the Sugar Go Down: Improve Management of Type 2 Diabetes
- Weighing the Evidence on Obesity



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](http://WWW.MASSMED.ORG/CMECENTER), OR CALL (800) 843-6356.