Inside the Fight for Women’s Reproductive Health Care
Q&A with the Physician Leader of Planned Parenthood League of Massachusetts

The availability of family planning services is narrowing as a result of actions and decisions by the federal government and the Supreme Court, including anticipated changes that would reduce patients’ access to a broad range of health care services and limit physicians’ ability to provide evidence-based medical care. Vital Signs asked Jennifer Childs-Roshak, MD, MBA, president and CEO of Planned Parenthood League of Massachusetts (PPLM), a leading provider of reproductive health care and evidence-based sex education, what the recent decisions and proposed changes mean for patients and physicians in Massachusetts and the country.

Q: How are politically driven policies on women’s reproductive health care affecting patients across the country?

Childs-Roshak: Politicians across the country have not been shy about trying to make abortion inaccessible. Political attacks also extend to preventive reproductive health care. When politicians rally around “defunding” Planned Parenthood, they are championing an effort that will prevent millions of women, men, and young people from accessing the preventive care they need. [PPLM health centers] often serve as a gateway to the larger health care landscape, and the people most harmed by these attacks are those who already face significant barriers to care: people with low incomes, people who live in rural areas, people of color, and the LGBTQ community.

So far, we’ve been able to defeat “defunding” efforts on the federal level, but many states are pursuing similar tactics that would keep their residents from accessing preventive care. If anyone questions the impact of these defunding schemes, I tell them to look at Indiana, whose former governor, Vice President Pence, issued budget cuts that led to the closure of a Planned Parenthood health center. That county was left without any HIV-testing provider, and, subsequently, an outbreak of HIV occurred. In the first quarter of 2018, 37 states introduced 308 new abortion restrictions and we know that the more abortion restrictions a state imposes, the worse women and children’s health outcomes are.

Every year, PPLM provides health care to over 30,000 patients across Massachusetts. Its services include routine exams and screenings, birth control, testing and treatment for infections, HPV vaccination, gynecologic care, pregnancy testing and counseling, abortion, and gender affirming hormone therapy. PPLM’s sexual health education programs reach over 12,000 people a year.

Dr. Childs-Roshak, a family physician, is the first physician to lead PPLM and Planned Parenthood Advocacy Fund of Massachusetts. She serves on the Board of Directors of Physician Health Services, Inc., an organization founded by the Massachusetts Medical Society.

Q: Are physicians in Massachusetts protected from political restrictions to their patient care?

Childs-Roshak: The overwhelming majority of Massachusetts voters and lawmakers support reproductive rights and health care, but we are not immune to politically motivated efforts to restrict access to care.

Every year, a small but vocal minority of activists and politicians introduces various bills that would wedge the state in between physicians and their patients. These bills would require physicians to provide state-scripted counseling, arbitrarily ban certain medical procedures, and require abortion providers to meet medically unnecessary requirements. These same groups work against nearly every effort to proactively improve access to reproductive health care and sex education, making it that much harder to close gaps in care and address disparities.

The Supreme Judicial Court has ruled the Massachusetts Constitution protects the right to safe, legal abortion, regardless of the status of Roe, and efforts to continue on page 4

Is the Medical Profession Finally Standing Up to Sexual Harassment?

BY LUCY BERRINGTON, MS

In the past two years, as sexual harassment has become a national talking point and high-profile figures were held accountable for years of inappropriate behaviors, the evidence mounted that medicine is not more virtuous in this regard than other industries. Surveys and perspectives were published in medical journals and the mainstream media, #MeTooMedicine emerged as a Twitter hashtag, and physician leaders lost their jobs — adding up to the message that conventional approaches have failed to prevent or address sexual harassment in the medical workplace.

Yet that same evidence also speaks to an increased recognition of sexual harassment and its broad, negative impact on individuals and organizations within the medical profession.”In the past year, more people have come forward [to report harassment] than in previous years,” says Jo Shapiro, MD, director of the Center for Professionalism and Peer Support at Brigham and Women’s Hospital, which handles cases of sexual harassment involving physicians.

Endemic Harassment

A report by the National Academies of Sciences, Engineering, and Medicine, released in June, placed a justifiably harsh spotlight on sexual harassment in the STEM fields and academic medicine in particular. Surveys suggest that the sexual harassment of women on medical faculties and women medical students is endemic. Research on
What It Takes for Women in Medicine to Be Seen and Heard

BY TOM FLANAGAN, MMS MEDIA RELATIONS MANAGER

Julie K. Silver, MD, has diagnosed a problem in medicine: the low visibility and silencing of women physicians. And although the physical symptoms may not be obvious to all — that is, after all, the issue — it has lasting negative consequences. Increasingly, medical professionals are railing in support of a cure. “There is a loud, loud roar about women being silenced and being made invisible. Women are unifying, together with many male allies, both virtually and in real life,” says Dr. Silver.

The erasure of women’s presence and voices in medicine and STEM fields generally — intentional or not — has driven Dr. Silver’s research, advocacy, and action for several years. Dr. Silver, associate chair and associate professor in the Department of Physical Medicine at Harvard Medical School and staff physician at MGH, BWH, and Spaulding Rehabilitation Hospital, has become a leading voice in the movement to increase the visible presence of women physicians both within the profession and societally.

“I decided to really show how women are being silenced,” Dr. Silver says. Her efforts gained national exposure in October 2016, when STAT published her critique of gender-based dynamics in medicine, “Invisible women: Female doctors and health care leaders are being hidden in plain sight.”

Fewer Awards and Authorships

The stark gender differences in physicians’ professional experiences are evident in salaries (see page 3), promotions, research funding, consumer-facing marketing materials, and more. “My research with colleagues has shown that women are not recognized for their important work, and their knowledge and insights are not valued,” says Dr. Silver. “For example, in several studies we showed that women physicians, in both surgical and non-surgical specialties, often receive none of the prestigious recognition awards given by medical societies. Women physicians are conspicuously absent as award recipients in categories such as lectureships where they would have an opportunity to speak to their peers and help shape the future of the specialty.”

A recent study Dr. Silver co-authored showed that although most pediatricians are women, women pediatricians are “underrepresented in all four high-impact pediatric journals for perspective-type articles” (JAMA Network Open, July 2018). “Silencing women physicians has had a profound and irrevocably damaging effect on the health care workforce,” she says.

Sidelines in Grand Rounds

Emerging data is also highlighting the suppression of women in Grand Rounds. A research letter published in JAMA in March 2017 pointed out that “women’s representation among academic Grand Rounds speakers falls below the percentage of female medical students and residents and often falls lower than faculty.” In addition, women physicians are not implicitly presented as or with their male colleagues. “Even when women are invited as Grand Rounds speakers, they’re introduced less formally and often not called Doctor,” Dr. Silver says. A 2017 study in the Journal of Women’s Health found that women introducing a male speaker used his formal title 95 percent of the time on first reference. Fewer than 50 percent of the male introducers used women speakers’ professional titles on first reference.

“Small” Biases Contribute to Major Discrimination

Research is showing the cumulative impact of such everyday instances of bias. “In medicine, microinequities and microaggressions are often so pervasive that some people think it’s OK to be slightly disrespectful and just a bit condescending to women,” says Dr. Silver. “Actually, a culture of microinequities promotes microinequities — a culture where even more egregious behaviors, unethical and sometimes even criminal, may be fostered. Paying women less for equal work is outrageous, and increasingly illegal, as it should be.”

Walls Do Talk

Dr. Silver is tackling the issue on multiple fronts. Last year, during the annual Harvard Women’s Leadership CME course, she spearheaded the Walls Do Talk Challenge. The contest was designed to highlight the implicit bias familiar in the “honor walls” of many medical and academic institutions. The hallway portraits were unrepresentative of women and minorities, skewing the image of what a leader in medicine looks like, Dr. Silver pointed out.

Walls Do Talk encouraged medical students to design their own vision of a wall that would honor and inspire those who have made and will make significant impacts in medicine. “Walls Do Talk was a challenge that may be replicated by other institutions, but already has had a significant impact, especially at Harvard Medical School (HMS), where the issue of the walls being inclusive is being actively addressed,” Dr. Silver says. In June, HMS announced that it planned to relocate 31 portraits — all but one depicting white men — from a Brigham and Women’s Hospital amphitheater as part of its ongoing efforts to honor the increasing diversity of the profession.

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Massachusetts Physicians Push the AMA to Lead on Gender Pay Equity

The American Medical Association has made a far-reaching commitment to advancing gender pay equity in medicine, in an advocacy effort spearheaded by two Massachusetts physicians.

The AMA delegates overwhelmingly voted to support a broad resolution — "Advancing Gender Equity in Medicine" — at the AMA Annual Meeting in June. The final resolution amalgamated four others, two of them brought by MMS members Julie K. Silver, MD, and Michael S. Sinha, MD, JD, MPH. "Our goal was simple: get the largest medical society in the United States to lead the way in adopting a set of highly proactive gender equity initiatives," Drs. Silver and Sinha wrote in a piece published by Doximity.

Gender Pay Gap Widening
In recent years the wide gap between men and women physicians' compensation has generated startling survey findings and headlines. On average, female physicians with equivalent training to their male counterparts earn 28 percent less (about $105,000 less) a year, according to the Doximity 2018 Physician Compensation Report. The gap has widened since 2016 when Doximity reported a 26.5 percent, or $91,284, difference in pay between male and female physicians.

"Even when other factors are held constant, women are still being paid less," says Dr. Sinha, a research fellow at Harvard Medical School. "You’re being paid less over the course of your entire career, and that’s often based on the first salary you’re offered out of residency or fellowship. It takes a conscious focus on equal pay for institutions to remedy those disparities."

The AMA initiative drew on Dr. Silver’s ongoing work with medical societies as physicians’ allies in the effort to establish equitable workplaces. Dr. Silver, associate professor and associate chair in the Department of Physical Medicine and Rehabilitation at Harvard Medical School, told Vital Signs, “Our thought was that many other medical societies would follow.”

Breakthrough Resolution
The resolution commits the AMA to developing a report with recommendations on promoting gender equity in medicine, and to advocating for institutional, departmental, and practice policies that support pay equity. The delegates pledged to recommend immediate actions, including not asking for job applicants’ prior salary information, creating an awareness campaign to inform physicians about their legal rights, and hosting workshops on the role of medical societies in advancing women in medicine. The AMA also committed to evaluating its own inclusion of women members and supporting gender equity and equal pay within the organization. The final resolution incorporated elements of two other gender equity resolutions, drafted by Hena Patel, MD, a cardiology fellow, and Suriya Sastri, MD, a gastroenterologist, who both practice in Chicago.

Institutional Accountability
The AMA resolution implicitly recognizes that pay gaps reflect structural and systemic biases and calls for structural and systemic solutions, as opposed to relying on individuals to improve their salary negotiations skills. “If people from underrepresented groups (for example, women or ethnic minorities) get paid less, that’s a really big ethical and legal concern for leaders and institutions,” says Dr. Silver. “My work is about having change come from the leadership, from the people who have the most power and financial resources to drive change, as opposed to individuals who are discriminated against, which is not a reasonable approach. But at the same time, you can’t count on institutions to right-size and equilibrate, so trying to educate people about this is also important.”

Young Physician Leadership
The AMA House of Delegates’ support for the combined resolution followed the unanimous approval of the Young Physicians Section of the two resolutions developed by Drs. Silver and Sinha. "It was really important for the AMA to hear from the next generation that this is what they want," says Dr. Silver. "In this next generation, the majority of doctors come from one or more underrepresented groups. Early career physicians have been exposed to social justice issues in ways that physicians who were trained at an earlier time were not. They want everyone to be successful, to have a level playing field.”

That profile of young physicians dedicated to social justice issues and identifying as leaders was described in the 2015 Trends Identification Report of the Annual Association of Medical Society Executives: “Early career physicians are seeking to build trust with their medical societies on many levels. They want to have a hand in shaping the future of their organizations, co-creating products and services, and have increased desire for their organizations to be transparent, ethical, and socially conscious.”

The rise of dual-physician households is also contributing to increased awareness, says Dr. Sinha. "A lot of male physicians are married to female physicians and so they suddenly have their own personal and financial stake in some of these issues.”

Advocating for Equitable Policies
The resolution refers to several institutional, departmental, and practice policies that support pay equity. These include transparency around criteria for compensation; pay structures based on gender-neutral, objective criteria; improved oversight of compensation models and metrics; and training to mitigate implicit bias "with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.”

“There remains no medical specialty in which female doctors earn more than male doctors. Additionally, women earn less than men in all of the top 50 metro areas.”
— Doximity, 2018
Women’s Reproductive Health Care
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roll back reproductive rights have never succeeded in Massachusetts. Still, the current national political environment has emboldened politicians in state houses across the country, making it incumbent on all of us to stay vigilant in defending our rights and the rights of our patients.

**VS What will proposed changes to the federal Title X program, which funds family planning services for low-income women, mean?**

**Childs-Roshak** Access to affordable contraception, particularly long-acting reversible contraception, has had a profound public health impact. The US is experiencing a 30-year low for unintended pregnancies and unintended pregnancy among teens, and a record low in abortion rates. [The proposed Title X grant funding changes] would [In addition, the proposed] gag rule, barring any practice, hospital, or community health center that receives Title X funding from providing or even referring their patients for abortion, [violates] basic medical ethics by forcing providers to withhold health care information from patients. It harms patient health and destroys the trust patients have in their providers.

In Massachusetts, five Title X grantees care for 67,000 patients at 82 locations. [These changes] will leave many women, men, and young people with nowhere to turn for care, and will disproportionately hurt women of color.

If [the proponents of these changes] truly cared about reducing rates of unintended pregnancy and abortion, they would work with reproductive health care providers to improve access to effective contraception and evidence-based sex education.

**TITLE X**
Title X is the sole federal program dedicated to family planning services. According to the Office of Population Affairs, the Title X program supports about 4,000 safety-net family planning sites that collectively served four million women, men, and adolescents in 2016.

**Grant Changes**
In February, the administration released its Title X Funding Opportunity Announcement, which included a significant number of changes from previous years. Among the changes, the new criteria eliminate HHS/CDC’s evidence-based clinical Quality Family Planning Guidelines and focus on abortion and fertility awareness methods such as the “rhythm method,” as an approach to birth control.

**Proposed “Gag Rule”** (See story on page 5)
In June, the administration issued a proposed rule that would bar clinicians from specifically referring pregnant patients to abortion service providers, when explicitly requested. Clinics that receive Title X funds that cannot or do not comply with the new rules would lose Title X funding.

**VS What are the health and equality implications of the politicization of women’s health?**

**Childs-Roshak** The end goal of politicizing women’s health seems to be to control women’s bodies and, in turn, their lives. When women have full reproductive freedom and are able to choose if, when, how, and how many children they have, they are better able to plan for their futures and obtain their educational and professional goals. In fact, contraception has contributed to wage gains made by women since the 1960s and has helped shrink the gender pay gap.

Access to contraception played a critical role in increasing the number of women in professions, like medicine, that have been historically male-dominated. I never would have been able to finish college, no less medical school and a residency, without access to reliable birth control. A woman’s ability to time and space births as she sees fit also improves her health and well-being — and her family’s. It’s no surprise that [family planning] was named one the greatest public health achievements of the 20th century [by the CDC].

**VS How concerned are you about the potential for Roe v. Wade to be overturned?**

**Childs-Roshak** Whether it’s our administrative workload, patient volume, or other duties, we as physicians already have so much on our plates. The government shouldn’t be making it harder for us to care for our patients. In addition, reproductive health care providers face intimidation tactics against them, their staff, and their patients.

In 2017, the National Abortion Federation, an organization that tracks violence against abortion providers, counted the highest number ever of trespassing and picketing incidents at reproductive health centers since it started tracking in the 1970s. While our security staff and clinic escorts do a wonderful job creating a safe, welcoming environment, no one should have to worry about facing harassment or intimidation in order to simply do their job.
MMS Acts against Gagging Physicians on Reproductive Health Care

BY SARAH RUTH BATES, MBE, AND LUCY BERRINGTON, MS

The Massachusetts Medical Society is leading a statewide collaboration to oppose federal regulatory changes that would prevent providers from referring patients for abortion care. These proposed rules are only one manifestation of an ongoing effort by the federal government to undermine the provision of evidence-based women’s reproductive care across the country. If implemented, the changes will affect family planning clinics receiving Title X funding through a program established in 1970 with bipartisan support.

In response, the MMS has affirmed the importance of the principles under threat, including open patient-physician communication, the provision of evidence-based care, and the imperative to provide care to all. In a letter to the US Department of Health and Human Services in July, the MMS and a coalition of physician organizations argued that the proposed rules could irreparably damage the trust upon which the patient-physician relationship depends. The letter has been signed by the MMS, the Massachusetts Chapters of the American College of Physicians and the American Academy of Pediatrics, the Massachusetts Section of the American College of Obstetrics and Gynecology, the Massachusetts Academy of Family Physicians, the Massachusetts College of Emergency Physicians, and the Connors Center for Women’s Health and Gender Biology of Brigham and Women’s Hospital.

Preventing Abortion Referrals

The proposed changes seek to prevent physicians at Title X–funded facilities from referring patients for abortions, notwithstanding that abortion is a legal health care service. (Title X funds are not used to cover abortion care.) The administration has argued that this change would not constitute a gag rule because physicians would still be permitted to mention abortions to their patients. The MMS and its co-signatories hold that this is a specious distinction.

“If these rules go into effect, if a patient had an unplanned pregnancy and wanted to know her options, as a Title X grantee I would not be allowed to comprehensively counsel her on all of her options. If I did, I would risk losing Title X funding for the whole clinic,” says Megan Evans, MD, MPH, who currently practices at Neponset Health Center, which receives Title X funding, and at Tufts Medical Center.

Discriminatory Rules

The proposed rules would discriminate against women who seek care at Title X clinics, many of whom are of lower income. The changes are likely to lead to the closure of clinics and a reduction in health care services in the communities where those facilities currently operate. Title X facilities provide a spectrum of health care services, including screening for chronic disease and sexually transmitted infections, pelvic exams, contraception, health education, and referrals. The new rules would make it difficult or impossible for clinics receiving Title X funding to operate in a way that stays true to their mission while still complying with the law, says Julie Johnston, MD, medical director of Health Quarters, a network of Title X–funded clinics in northeastern Massachusetts, and the 2018 recipient of the MMS Women’s Health Award. “A clinic that meets the Title X criteria under Trump’s plan is not practicing good medicine. The government should not step between patients and their physicians in the context of a safe and legal health discussion.”

Importance of Speaking Out

Physicians’ voices are vital to ensuring that medical practice is not politicized, says Dr. Evans. “Physicians are highly trusted in the community. If we’re silent, we’re basically saying it’s OK. These changes are impacting our patients and general society in an enormous way. Contraception is key to women’s independence and improved economic status. When you jeopardize that, you’re jeopardizing generations and communities.”

Why Do So Many US Women Die from Pregnancy-Related Causes?

BY THERESE FITZGERALD, PHD, MMS DIRECTOR OF HEALTH CARE RESEARCH, ANALYTICS, AND INSIGHT

When Lauren Bloomstein, a neonatal intensive care nurse, gave birth to a healthy baby girl, her husband Larry, a physician, never dreamed he’d be leaving the hospital a single father. But just 20 hours after giving birth, Lauren was dead. A 2017 report by ProPublica and NPR describes in agonizing detail what led to Lauren’s death.

Lauren is one of more than 450 expectant and new mothers in the US who have died since 2011. The US ranks a dismal 47th in the world for maternal mortality rates, and is the only developed country in which maternal mortality is rising. Women of color and low-income women are disproportionately at risk.

Most Maternal Mortality Is Preventable

Maternal mortality is a key indicator of the quality of health care, both in the US and internationally. Public health experts have been sounding the alarm. According to a 2018 report involving nine state maternal mortality review committees — “Building US Capacity to Review and Prevent Maternal Deaths” — 60 percent of pregnancy-associated deaths (maternal deaths during pregnancy or within one year of pregnancy ending) are preventable. That statistic highlights the importance of identifying data trends as a key preventive step. Timely, granular data is not so easy to come by.

Behavioral Health as a Risk Factor

In Massachusetts — where maternal mortality is relatively low by US standards — physicians and public health experts are grappling with data limitations and inadequate resources. The opioid epidemic has made that challenge more acute. According to the Massachusetts Department of Public Health (MDPH), nearly half of all pregnancy-associated deaths are developed under Chapter 55, a state law that authorized the MDPH to link 20 data sources relevant to the opioid epidemic. The state’s Maternal Mortality and Morbidity Review Committee (MMRMC), which reviews each case of maternal mortality and makes recommendations aimed at improving outcomes, lags several years behind. “Right now, we’re looking at 2014–15 deaths. We’re so far behind that we couldn’t pick up the uptick in narcotics-related deaths earlier. That would have been helpful,” says Glenn Markenson, MD, professor of obstetrics and gynecology at Boston University School of Medicine, who sits on the committee.

The gap is in resources, not political will. Dr. Rebecca Lundquist, a psychiatrist and associate professor at the University of Massachusetts Medical School, who also sits on the committee, welcomes the Commonwealth’s attention to the intersection between behavioral health and maternal mortality: “I am proud to be in a state [where] there is a high degree of awareness at the legislative and executive branches regarding behavioral health and its impact on morbidity and mortality in pregnant and postpartum women.”
Standing Up to Sexual Harassment

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sexual harassment broadly has found that women of color are particularly likely to be targeted.

“My intuition is that the problem is at least as bad in medicine as elsewhere,” Reshma Jagsi, MD, DPhil, a professor of radiation oncology at the University of Michigan and the lead author of a 2016 JAMA paper on sexual harassment in medical education, wrote in NEJM in January: “And the data show that the problem for female physicians is certainly bad enough that the profession must work together to correct it.”

Effective Prevention Goes Far beyond Policy

Existing harassment policies and procedures are often symbolic and focused on avoiding liability, the National Academies found. Hospitals are not necessarily addressing the problem more effectively than universities. “Every hospital I know of has policy against sexual harassment and people you can report to. But the question is, are people using that system?” asks Dr. Shapiro.

The answer is no, surveys show. This reluctance reflects the belief, pervasive in medicine and academia, that the people reporting harassment will suffer negative career consequences. “I take that extremely seriously,” says Dr. Shapiro. “I’m most interested in making sure people are not harmed for having come forward with concerns.”

Easier Reporting, Fair Investigation

The Center for Professionalism and Peer Support at Brigham and Women’s is designed to foster a culture of “mutual respect, trust, and teamwork,” according to the hospital website. A key goal of the Center, which opened in 2008, has been lowering the barriers to reporting harassment. That means inviting employees to have a conversation rather than requiring them to file a formal report. It also means demonstrating fairness, both to the person reporting harassment and to the alleged perpetrator.

The success of such an approach depends on its sustained presence and visibility. “It takes a while to set up a whole program where this gets integrated into the fabric of the institution,” says Dr. Shapiro. “The fact that people are willing to come forward where they tolerated harassment for years, makes me think there is an increased sense of safety in reporting.”

Organizational Climate

Harassment is more common in hierarchical organizations, especially those that are perceived to tolerate it, research shows, which may help explain its prevalence in medicine and academia, the National Academies report pointed out. Harassment is less common in organizations that actively support inclusion, diversity, and respect.

The National Academies called for academic leaders at every level to “make the reduction and prevention of sexual harassment an explicit goal of their tenure.” The support of clinical leaders is vital, says Dr. Shapiro. “A department asked me to do a presentation on harassment. At the end, the chair stood up and said, ‘I want to make this really clear: we just will not tolerate this in our department.’ People are so relieved that the institution itself is not OK with harassment.”

Two Types of Perpetrators

Based on her own experience, perpetrators of sexual harassment divide into two types, says Dr. Shapiro. The first involves people who do not see their behaviors as intentionally malicious. “Our answer is it’s not about your intent, it’s about your impact. And it’s illegal. Anecdotally, from my experience, these are the ones who are more likely able to stop it when we make it obvious how harmful it is.”

The second type appears shrewder. “I think they know what they’re doing and use it as some sort of power thing. I think the only way they change is if they know it will harm them. The institution has to have the backbone to say, ‘If you do this again, or because you’ve done this, this and this is going to happen’ — potentially the loss of a leadership position or employment.”

MedPEP: Physicians Empowerment Podcast Tackles Burnout

BY DEANNA M. BIDDY, OUTREACH AND FUNDING COORDINATOR, PHYSICIAN HEALTH SERVICES, INC.

Marie Curious, MD, got down on the floor to play with her two young children and fell asleep there. Her day had been a series of challenging conversations with patients about their prescriptions, scrambling from one administrative task to another, liaising with staff, and responding to messages and phone calls. An urgent fax revealed that a long-term patient had died unexpectedly. After signing the death certificate, still shaken, she barely caught a breath before seeing her next patient. Making time for focused conversations means more “pajama time” — tending to cumbersome electronic health records after putting her children to bed.

Dr. Curious, a primary care internist, is early in her career. She already knows what it means to be overwhelmed by the demands of medicine. Unable to prioritize her family and her own needs, she has caught herself advising her daughter not to become a doctor like Mommy. Indeed, she has been contemplating a career change.

Medical Professionals Empowerment Program

But instead of quitting medical practice, Dr. Curious has augmented it — as the co-host of MedPEP, the Medical Professionals Empowerment Program, a podcast series from Physician Health Services (PHS). MedPEP is the story of Dr. Curious’s collaboration with Les Schwab, MD, an internist, physician coach, and medical leader, and their shared quest to rekindle the satisfactions that make medical practice sustainable. (Marie Curious is a pseudonym; her story is real.)

MedPEP is a result of efforts by PHS to provide a resource to assist physicians and health professionals singed by the flames of burnout. “We believe that physicians and other health professionals, individually and collectively, are mired in an occupational health crisis that is crying out for innovative solutions;” wrote Steven A. Adelman, MD, MedPEP’s founder, and Jane M. Liebschutz, MD, MPH, a MedPEP contributor, in the NEJM Catalyst blog (August 2017). “Dr. Marie Curious is emblematic of the thousands of talented and dispirited young physicians who are seeking knowledge, wisdom, and techniques for improving their lot.”

Burnout affects over 50 percent of physicians in the US, studies show. In the 20-episode series, Drs. Curious and Schwab meet with 16 experts to discuss the realities of contemporary medical practice and review a number of actionable physician empowerment strategies. These experts highlight self-care, conflict management, substance misuse, emotional intelligence, nutrition, dealing with bureaucracy and bosses, system improvement, and more. From episode to episode, Dr. Curious reports on how it’s working for her to implement these strategies in order to best care for herself and others.

Driving a Culture of Coaching

Systemic factors, including the intensifying requirements of regulation and EHR, are heavily implicated in physician burnout. MedPEP includes interventions that are applicable on multiple levels: individual, team, group, and system. “Many of the contributors discuss how organizations need to weave interventions into their daily standard work,” says Dr. Adelman, who directs PHS. “For example, when an individual doctor takes a mindfulness course, that’s an individual approach. When a clinic stops answering the phone at lunch, provides food, and offers everyone a mindfulness-based stress reduction lunch break, that’s a clinic-wide or organizational intervention.”

Introducing “a culture of coaching” into the profession and the system is a key goal. “That, in and of itself, is a systemic intervention. To the extent that coaching helps individuals become more effective, those individuals and their enhanced efficacy become more effective change agents at the level of the team, organization, and system,” says Dr. Adelman.

MedPEP episodes are being released weekly. Find them at MedPEP.org, Google Play, and iTunes.
MMS Member News and Notes

Robert A. Baldor, MD (University of Vermont College of Medicine, 1983; residency: UMass), was the 2016 recipient of the Allen Crocker Health Services Award for his clinical work with people who have developmental disabilities. Dr. Baldor is senior vice chair and professor of the Department of Family Medicine and Community Health at UMass Medical School and UMass Memorial Medical Center.

Paul D. Biddinger, MD, FACEP (Vanderbilt University School of Medicine, 1998; residency: BWH/IGH), was named the inaugural incumbent of the MGH Endowed Chair in Emergency Preparedness. At MGH, Dr. Biddinger is chief of the Division of Emergency Preparedness and director of the Center for Disaster Medicine; he is associate professor of emergency medicine at HMS.

Rachel J. Buchsbaum, MD (Cornell Medical College, 1983; residency: BIDMC), was named the Tufts Medical Center Jane F. Desforges, MD, Chair of Hematology and Oncology, which supports an outstanding faculty member whose work strengthens teaching and research in hematology and oncology. Dr. Buchsbaum is chief of the Division of Hematology/Oncology at TMC and associate professor of medicine at TUSM.

Karen M. Freund, MD, MPH (Stanford School of Medicine, 1983; residency: Cambridge Health Alliance), was awarded the 2018 Milton O. and Natalie V. Zucker Prize for a career of research excellence. Dr. Freund is interim physician-in-chief of the Department of Medicine at TMC and professor of medicine at TUSM.

Sachin H. Jain, MD, MBA (HMS, 2008; residency: BWH), was named #31 on Modern Healthcare’s Most Influential Physician Executives list for 2018. Dr. Jain, president and CEO of CareMore Health, was praised for expanding the care delivery system’s geographic reach and launching the CareMore at Home model, which serves patients unable to travel for care. Dr. Jain is a consulting professor of medicine at Stanford and a contributor at Forbes.

Mark A. Keroack, MD, MPH (HMS, 1980; residency: BWH), became the 78th Chair of the Mass. Health and Hospital Association (MHA) Board of Trustees. Dr. Keroack, who specialized in internal medicine and infectious disease, is the president and CEO of Baystate Health and board chair of Health New England, its subsidiary health plan.

Elisabeth T. N. Phung, DO (Nova Southeastern University, 2013; residency: Allegheny General Hospital), will join the faculty at Johns Hopkins Bayview Medical Campus in Baltimore, Maryland, this fall as a clinical associate and medical director of the Beacham Center for Geriatric Medicine.

Dallas A. Reed, MD (BUSM, 2010; residency: Bridgeport Hospital), was among the 2018 winners of the Innovations in Diversity Education Awards (IDEAs), an intramural grant program encouraging research in workplace diversity, health care disparities, and cultural competency. Dr. Reed, along with co-author James Yao, MD, chief of colorectal surgery at Tufts Medical Center, developed a pilot program to increase the diversity of TUSM applicants. Dr. Reed is an obstetrician/gynecologist and medical geneticist at TMC and an assistant professor at TUSM.

Steven L. Strongwater, MD (SUNY Upstate Medical U.), was named Physician of the Year by the Home Care Alliance of Massachusetts. As president and CEO of Atrius Health, Dr. Strongwater led the charge for new home health and hospice services. Dr. Strongwater serves on several boards including the Mass Digital Health Council, IBM Watson Advisory Board, and Janssen Healthcare Innovators Council.

ACROSS THE COMMONWEALTH

District News and Events

NORTHEAST REGION

CHARLES RIVER — Executive Committee Meeting. Mon., Sept. 24, 6:30 p.m. Dr. McCann’s Home. Family Outing. Sat., Sept. 29, 12:00 p.m. Community Rowing, Brighton.

ESSEX SOUTH — Annual Clambake. Sat., Sept. 15, 1:00 p.m. Coffin Beach, Gloucester.

MIDDLESEX — Fall Family Outing. Sun., Sept. 16, 11:00 a.m.–4:00 p.m. Kimball Farm, Westford.

MIDDLESEX CENTRAL — Executive/Delegates Meeting. Thurs., Sept. 20, 7:45 a.m. Emerson Hospital, Concord.

SUFFOLK — Students, Residents, and Young Physicians Reception. Thurs., Sept. 27, 7:00–9:00 p.m. Clery’s, Dartmouth Street, Boston.

Contact Michele Jussaume or Linda Howard at (800) 944-5562 or mjussaume@mms.org or lhoward@mms.org.

SOUTHEAST REGION

BARNSTABLE — Family Fall Event. Sun., Sept. 30, 11:00 a.m. Edaville Railroad, Carver.

PLYMOUTH — Family Outing. Clambake Sun., Sept. 16, 1:00 p.m. J. Eric Jonsson Center, Woods Hole.

BARNSTABLE, BRISTOL NORTH, BRISTOL SOUTH, NORFOLK SOUTH, PLYMOUTH — Southeast Regional Caucus. Tues., Nov. 20, 6:00–9:00 p.m. LeBaron Hills Country Club, Lakeville.

Contact Sheila Kozlowski, at (800) 322-3301 or skozlowski@massmed.org.

WEST CENTRAL REGION


HAMPDEN — Executive Board Meeting. Tues., Sept. 25, 6:00 p.m. Hampden District Office, West Springfield. Fall District Meeting. Wed., Oct. 10, 6:00 p.m. Starorrown Carriage House, West Springfield. Speaker: MMS President Alain Chaoui, MD. Topic: Heal the Healer; Take Back the Joy of Medicine. Contact Coni Fedora at (413) 736-0661 or hdm@massmed.org.


Contact Cathy Salas at (800) 522-3112 or csalas@mms.org.

STATEWIDE NEWS AND EVENTS

ARTS, HISTORY, HUMANISM, AND CULTURE MEMBER INTEREST NETWORK — Hawk Migration. Sat., Sept. 22, 1:00–3:00 p.m. (Rain date: Sat., Oct. 6). Wachusett Meadow Wildlife Sanctuary, Princeton. An Introduction to the natural history of New England birds of prey and fall migration. Contact Cathy Salas at (800) 522-3112 or csalas@mms.org.
The Nature and Impact of Sexual Harassment

Identifying Harassment
The most common forms of sexual harassment are gender-based, according to the National Academies — “behaviors that communicate that women do not belong or do not merit respect,” such as hostility, objectification, and exclusion. Sexual harassment also includes unwanted sexual advances and sexual coercion.

Professional and Health Harms
Sexual harassment undermines professional and educational attainment, research shows. The National Academies warned of the “costly loss of talent” resulting from sexual harassment and urged institutions to consider it as important as research misconduct in its negative effect on the integrity of research.

Sexual harassment also affects the mental and physical health of people targeted. “The long-term effects of sexual harassment in the workplace have not been well researched,” says Maria G. Michas, MD, MPH, FACOEM, medical director of Employee Health Services, Occupational Injury Care & Wellness, at UMass Memorial Health Care. “In a study of more than 500 cases, 46 percent of women said the harassment interfered with their work performance. Thirty-six percent reported nausea, vomiting, depression, headache, or drastic weight change. Sexual harassment has also been reported to result in increased sick leave, decreased productivity, increased job turnover, and litigation.”

See "Is the Medical Profession Finally Standing Up to Sexual Harassment?" on page 1.