Educational Outreach Planned on Marijuana, Suicide Ballot Questions

BY ERICA NOONAN

The Board of Trustees voted earlier this month to distribute educational materials to members to explain the Society’s opposition to two controversial questions on the November 6 Massachusetts ballot.

The Society opposes Question 2, which would allow a physician licensed in Massachusetts to prescribe life-ending medication at a terminally ill patient’s request. The Society’s position stems from longstanding opposition to physician assisted suicide by the MMS House of Delegates. That position was reaffirmed in a December 2011 vote.

The MMS also opposes Question 3, a proposal to legalize medical use of marijuana. At the MMS Annual Meeting in May, the House of Delegates voted that until scientific studies demonstrate the “safety and efficacy” of medical marijuana, the Society would oppose its legalization.

The Society also advocates that marijuana be reclassified by the DEA so its potential medicinal use can be further studied. The Society also supports the development of non-smoked delivery systems for cannabis-derived medication for research purposes.

Educational Mailing Planned

The Society will mail educational materials with background on both ballot questions, as well as more information on MMS policy, to all members with Massachusetts addresses.

Additional copies will be made available to member physicians who

Managing the New Realities of Care in the Commonwealth

BY DEBRA BEAULIEU

Massachusetts’ new cost-containment law, passed this summer, makes ambitious promises for the patients — and finances — of the Commonwealth. The most ambitious goal within the 349-page reform bill is to save the state $200 billion during the next 15 years by vigorously promoting, yet not mandating, alternate payment methodologies for physicians. As part of this massive initiative, patients have been told to expect high-value, well-coordinated care, along with greater transparency into the quality and cost of the care their physicians recommend.

The Massachusetts Medical Society has applauded many aspects of this next phase of our health reform law, particularly the inclusion of a “disclose, offer, and apologize” approach to addressing adverse medical events. At the same time, however, there are questions as to how exactly physicians will manage the new realities of providing care in the Commonwealth.

While the law doesn’t require physicians to abandon fee-for-service payment methodologies, for example, those on the less-ready end of the continuum will have to quickly get up to speed as to how risk-based relationships may or may not work for them. And regardless of any voluntary changes doctors make to their practices, the enhanced reporting requirements under the bill may add a substantial administrative burden for many.

“These laws are not designed with doctors in mind,” said Stephen Johnson, M.D., director of neurosurgery at South Shore Hospital, affiliate surgeon at Brigham and Women’s Hospital and physician at South Shore NeuroSpine Group. “I think it’s been a long time since anybody cared what doctors were inconvenienced by or what they thought about or how it affects them,” he said.

That’s not to say that physicians aren’t pleased with the law’s potential to improve the overall health of their patients. For example, the bill earmarks $60 million over the next four years to enhance community-based disease prevention and public health. For the first time, employers who implement workplace wellness programs will be eligible for tax credits of up to $10,000.

This is a good start, said Denise Mills, M.D., a solo family physician in Dracut and past president of the Middlesex North District Medical Society. “But I would have liked to have seen a similar tax benefit or other carrot on a personal basis for those patients who, for example, quit smoking or lower their BMI by a certain percentage. There is not enough enticement at present for the individual to ‘own’ his or her health.”

continued on page 2

Behind the Scenes: Physician Focus TV Program Tapes 100th Episode

A behind-the-scenes view of Physician Focus preparing to tape its 100th episode. Inset: From left: Bruce Karlin, M.D., Catherine Brown, D.V.M., and Alfred DeMaria, M.D., film a separate episode about mosquito- and tick-borne diseases.
A Busy Fall on Beacon Hill

Fall is often a time for new beginnings, and this season is no exception.

We at the MMS spent much of the summer on Beacon Hill, witnessing health care legislative history unfold.

It was a thrill to stand near Governor Deval Patrick and Massachusetts Health and Human Services Secretary JudyAnn Bigby, M.D., as the state’s ambitious new payment reform bill was signed into law.

After the ceremony, Dr. Bigby and I discussed how the MMS may continue to contribute to a piece of legislation that, among other things, will help improve care, reduce costs, and reform the state’s troubled medical liability system.

Just a few weeks later, Gov. Patrick signed into law provisions to increase participation in the state’s Prescription Monitoring Program (PMP) by prescribers. The bill, contains provisions that the MMS had advocated for, such as automatic enrollment and a required check of the database only for new patients.

In November, Massachusetts voters will vote on whether to legalize medicinal marijuana and physician assisted suicide. As you see in our Vital Signs cover story this month, the Society has gone on record in opposition to both of these ballot questions after many hours of thoughtful debate by your delegates. Because of the public and media interest in these issues, you will be receiving additional communication this fall from us about the ballot issues, as well as an explanation of the Society’s positions.

We’ll also be looking to you to tell us about your experiences in this ever-changing health landscape. Our effective advocacy would not be possible without your support.

— Richard V. Aghababian, M.D.

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www.massmed.org
Affordability is Top Issue for Both Healthy and Sick Massachusetts Residents

In late July 2012, the Massachusetts Legislature passed a law to control the rising cost of health care. This legislation is particularly timely, as two recently published research studies, one by the MMS and one by the Blue Cross Blue Shield of Massachusetts (BCBS-MA Foundation), found that among both healthy and sick adults in Massachusetts, the cost of care is considered a serious problem for the state.

The BCBS-MA Foundation study found that approximately 78 percent of sick adults see the cost of care as a “very serious” or a “somewhat serious” problem, whereas half of the overall adult population in the state found the cost of care as a significant problem.

The MMS study demonstrates that among adults living in the Commonwealth, access to primary care physicians has improved in 2012, although nearly half of primary care practices are still closed to new patients. Despite limited accessibility, the MMS study found that 87 percent of all adults in Massachusetts are satisfied with the health care they have received. Among sick adults in Massachusetts, however, nearly 40 percent believe that the quality of health care in the state is problematic. Sick adults concerned about the quality of care in the state also noted their most pressing concerns involved the cost of health care.

The study by the MMS and the study by the BCBS-MA Foundation both used the same telephone survey methodology; however the MMS study focused on all adults in Massachusetts, whereas the BCBS-MA Foundation study focused on only “sick adults” in the Commonwealth. “Sick adults” are defined in the BCBS-MA Foundation study as those with a serious illness, medical condition, injury, or disability requiring a lot of medical care or who had been hospitalized overnight in the previous 12 months.

The BCBS-MA Foundation’s study, “Sick in Massachusetts: View on Health Care Cost and Quality,” can be accessed at www.bluecrossfoundation.org. The MMS “Patient Access to Care” study can be accessed at www.massmed.org/patienaccess. VS

— Melissa Higdon

SPOTLIGHT ON SUCCESS

Navigating Medicare Reimbursement Changes

With Medicare reimbursement changes starting to take effect, providers must act immediately to remain financially viable. The most important aspect of any strategy hinges on creating a culture of savvy business decisions, data use and inference, and management practice. Above all, clinical quality and performance — the new major player in reimbursement — can be streamlined. A review of several national practices successfully navigating these changes produced the following key approaches:

• Conduct a financial audit and design and implement a financial strategy. A financial audit will help identify weaknesses or gaps in current financial performance. In one example, a large practice noticed that they had some variation in financial performance between departments. They re-arranged their management structure to allow for more equally distributed control, which increased efficiency across departments and decreased operating costs significantly.

• Develop financial benchmarking strategies. Consider developing financial benchmarking across providers with internal comparison, as well as comparison to externally recognized industry benchmarks. For a practice lacking IT infrastructure, investing in an electronic health record system and proper training is a reasonable solution. However, such a change is useful only if it is closely monitored for efficiency improvement.

• Implement a routine holistic practice review of cost drivers. One group instituted a competitive, team-based initiative focused on accountability and streamlined progress. This effort focused the providers on rapid self-improvement, with teams reporting gains at monthly check-ins each quarter. The effort proved successful, as wasteful procedures, incomplete registrations, and average hospital length of stay all decreased, saving the group millions of dollars.

Understanding the financial health of your practice is key. Choosing and focusing on a strategy will ultimately result in improvements to quality, efficiency, and financial success. Gaining ground in these areas will continue to be a major theme in this new era of health care. VS

— Leif Brierley

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Pertussis 2012: The Worst Year since 1959?
Reports of Whooping Cough Soar

Reports of soaring whooping cough incidence are dominating the news this year. With more than 18,000 cases of pertussis reported nationally in 2012 so far, the U.S. is well on track for record-breaking numbers. “We may have to go back to 1959 to find a year with as many cases reported,” commented Anne Schuchat, M.D., director of the CDC’s National Center for Immunization and Respiratory Diseases, in a briefing last month.

Within Massachusetts, there have been approximately 379 confirmed cases of pertussis as of mid-August, three times as many this year as in the same time frame in 2011. In February, Massachusetts experienced its first pertussis-related infant death since 2002, and at least 21 other young infants have experienced illnesses requiring hospitalization in 2012.

The Massachusetts DPH’s Immunization Program has issued two clinical advisories concerning pertussis in 2012: to alert health care providers to the need for vaccination in all age groups, particularly in pregnant women and their families, and to encourage early diagnosis and treatment of pertussis, even in vaccinated patients.

Why the Increase? Lack of Vaccination, Waning Immunity, and Vaccine Efficacy

There are many potential contributing factors in Massachusetts and nationally:

• Our adult and adolescent populations are undervaccinated. Estimated Tdap vaccination coverage among adults was at only 19 percent in 2011. Adolescent rates were higher at 82 percent. Vaccination of pregnant mothers and their household holds is critical for the protection of every newborn.

• Immunity gradually wanes following either vaccination or pertussis infection and this loss of protection appears to occur more quickly with acellular pertussis vaccine compared to whole-cell pertussis vaccine.

• Providers may not suspect pertussis in vaccinated patients, which delays diagnosis, testing and treatment.

Vaccination of all health care workers is also essential.

• Pertussis vaccine itself is not 100 percent effective in preventing disease (estimates of efficacy range from 80 to 85 percent).

Stopping the Spread

Patients with pertussis are considered infectious from two weeks before cough onset through the third week after cough onset, or through the completion of five days of appropriate antibiotic treatment. The long infectious period of pertussis contributes to the continued spread, particularly in school and day-care settings.

The DPH no longer recommends broad-based prophylaxis, instead focusing on house-hold contacts and other individuals at high risk for developing complications or those that could possibly transmit disease to high-risk patients (this includes diagnosing clinicians).

If you have questions regarding pertussis diagnosis, treatment, and/or control, do not hesitate to call your local board of health or the DPH Immunization Program at (617) 983-6800. An epidemiologist is on call 24 hours a day and can provide further guidance. More information about pertussis is available on the DPH website at www.mass.gov/dph/imm.

— Hillary A. Johnson, MHS
Epidemiologist/Massachusetts DPH

Massachusetts DPH Recommendations

• Health care providers should have a high index of suspicion and should include pertussis in their differential diagnosis for patients in all age groups who present with prolonged cough illness, regardless of vaccination status.

• Laboratory confirmation is challenging. The appropriate test depends on the child’s age and cough duration.

• The earlier antibiotics are started, the more effective they are at preventing transmission and possibly modifying illness. This is particularly important for infants whose course of illness may progress rapidly.

• Vaccination is still the best protection. Make sure you and your patients (particularly pregnant women) are up-to-date with DTaP and Tdap immunizations.

37th Annual Joseph Garland Lecture — Writing a History of Cancer: An Epilogue

Speaker: Siddhartha Mukherjee, M.D., assistant professor of medicine at Columbia University and an oncologist at the Columbia University Medical Center. He is the author of The Emperor of All Maladies: A Biography of Cancer, which won the 2011 Pulitzer Prize for General Nonfiction.

When: Thursday, October 11, at 5:30 p.m.
Location: Armenise Amphitheatre, Armenise Building, HMS, 200 Longwood Ave., Boston
Sponsored by the Boston Medical Library in the Francis A. Countway Library of Medicine

For more information please contact Roz Vogel at (617) 432-4807 or rvogel@hms.harvard.edu.

Vaccination is still the best protection. Make sure you and your patients (particularly pregnant women) are up-to-date with DTaP and Tdap immunizations.
Health Care-Focused Legislative Session Ends

The Massachusetts Legislature ended its 2011–2012 formal legislative session in late July with a flurry of activity. This fall and winter we will be seeing many regulatory actions as newly passed laws go into effect, creating new agencies, mandates, and responsibilities.

For example, this session’s sweeping payment reform legislation, Chapter 224, creates several new entities. A new and independent health policy commission will oversee cost growth and monitor accountable care organizations (ACOs) with provisions for voluntary certification. There are also provisions for registration of provider organizations, including exemptions for smaller non-risk bearing groups. A health planning council will inventory resources and make recommendations for appropriate supply and demand, and the new Center for Health Information and Analysis is slated to be the sole depository for health care data.

Increases in transparency on cost and quality will also likely see implementation through new regulations with a goal of providing patients with specific information on the costs of their care.

MassHealth, while already moving on projects for dual-eligible patients and medical homes, will be working under specific legislative mandates to reach significant goals for the use of global payments for increasing percentages of its beneficiaries.

One MMS goal, Disclosure, Apology and Offer, has been achieved through Chapter 224. We look forward to the implementation of the program and progress towards increases in patient and provider satisfaction with the process for resolving issues around unanticipated outcomes of care.

An additional area of interest to the MMS includes new provisions to address physician workforce issues, including a loan repayment program for primary care physicians (PCPs) in underserved areas and state funding for PCP’s graduate medical education.

New regulations will be required by the Board of Registration in Medicine on training for physicians in disclosure of adverse events and the DPH will be kept busy developing wellness programs that the new law funds.

Other significant issues this legislative session include:

- **Prescription Drug Monitoring.** On the final day of formal session, S.2125, “An Act Relative to Prescription Drug Diversion, Abuse and Addiction,” was passed. The MMS worked hard to amend an earlier bill mandating all physicians to sign up for the DPH’s prescription monitoring program.

- **HIV Testing.** At this session, the MMS and a coalition of providers who treat AIDS patients and HIV-positive patients worked extensively to modify legislation that mandated specific HIV testing and treatment protocols for all physicians and virtually all patients. The MMS succeeded in removing mandates and in passing legislation that for the first time amended the state’s absolute statutory requirement of written informed consent before administering an HIV test. The law did not go so far as to integrate HIV testing and treatment information into medical records — as the Society had hoped. Hospitals, clinics, and physicians are struggling with how to interpret the law in today’s environment.

- **Scope of Practice.** This session saw wins and losses as a wide array of health professions sought increased roles within ACOs and other new delivery models. Nurse-midwives saw significant steps toward independent practice. Nurse practitioners and physician assistants also had expansions of authority to sign documents and reductions in supervisory requirements respectively. Podiatrists and optometrists did not win in their efforts to increase their authority though, and naturopaths were also defeated in their efforts to become licensed. V5

— William Ryder

Medicare Payment Rule Changes for 2013 Announced

Over the summer, the Centers for Medicare and Medicaid Services (CMS) outlined proposed changes to the 2013 Medicare Physician Payment. Key issues included in the proposed rule include:

- **Sustainable Growth Rate.** CMS projects a 27 percent Medicare physician payment cut to take effect on January 1, 2013, unless Congress intervenes.

- **Physician Quality Reporting System.** For 2013 and 2014, CMS proposes to include 264 individual measures, along with 26 group measures, for 2013 — 4 more than 2012.

- **Value-Based Payment Modifier (VBM).** Created in the Patient Protection and Affordable Care Act (ACA), the VBM will lead to payment adjustments based on a comparison of physicians’ cost and quality. The proposal is budget-neutral, so increases in Medicare payment rates for some physicians will be offset by reductions for others. In the proposed rule, the VBM would be applied to groups of 25 or more physicians in 2015 and to all physicians by 2017. CMS previously stated its intention to base 2015 payment adjustments on data from 2013, despite widespread opposition from the MMS and AMA. The MMS advocated strongly against the VBM during ACA negotiations and will continue to oppose any quality measurements that are not scientifically valid, verifiable, and fail to meet the MMS’s criteria for quality measurements.

- **Electronic Prescribing (eRx) Incentive Program.** CMS proposes the addition of two hardship exemption categories tied to participation in the meaningful use electronic health record incentive program and the establishment of a process so that physicians encountering problems associated with 2013 e-prescribing incentives and the 2014 penalty program can request a formal review. CMS also proposes lowering the reporting requirement for eligible group practices comprised of 2 to 24 health care professionals. In addition, CMS proposes updating certain e-prescribing technological standards under Medicare Part D to improve e-prescribing functionalities.

The MMS and the AMA will be submitting detailed comments on these proposals, which will be posted on the MMS website when available. Final regulations are expected from CMS in November.

— Alex Calcagno
Empathy is challenged by many factors beleaguering health care today. We are at a time in medical history when physicians are facing more training requirements and compliance metrics than ever before, ranging from incentives for hand washing to required communication skills training to improve patient satisfaction.

In addition, physicians are facing tremendous pressures in terms of the number of patients they are expected to see, the short amount of time in which they have to see them, the complexity of the health problems, and increasingly burdensome documentation requirements.

When physicians are encouraged to take empathy training it’s not surprising that some respond, “Not one more thing!”

Many studies have documented a decline in physician empathy, which appears to begin in the third year of medical school and persists during residency. In the past, empathy rebounded after the rigors of training were over, but now that the pressures continue to mount, at least 60 percent of physicians practicing medicine today are demonstrating signs of burnout, according to a recent Mayo Clinic study.

Medical trainees, who once learned the bedside manner by observing master clinicians sitting down with patients and talking with them about their concerns, are now more likely to observe hurried and harried residents moving in a blur from patient to patient, taking no time to sit down and explain what is going to happen to that individual.

Patients report feeling increasingly anxious and disconnected from their physician.

The research team in the Empathy and Relational Science Program at Massachusetts General conducted a study of the effectiveness of the three, 60-minute empathy training modules in residents. Our study showed statistically significant improvement in patient perception and ratings of physician empathy with this brief intervention. The courses have been translated into self-paced, Web-based training for broad application that is CME and risk management certified by the MMS.

One of the most frequently asked questions is, “Doesn’t showing empathy just add more time to a busy doctor’s day?” The answer is no. Empathic care does not have to take more time.

Training helps medical care providers pick up on subtle emotional cues and nuances that indicate patient concerns so they can be addressed right away. Also, conveying empathy puts patients at ease and increases trust in the relationship, so that small problems do not have to become larger problems before they are addressed. Most patients know that their physicians are very busy, and connecting with them in a humane way does not have to take more time. Multiple studies have demonstrated that better medical outcomes are also correlated with strong empathic and relational skills.

In addition to greater patient satisfaction, doctors found that by connecting with their patients more meaningfully, they experienced the personal thrill that providing compassionate care brings to their own lives.

One doctor said, “After this training, I feel that I like my work again, and instead of resenting all the demands, I’m remembering why I chose this profession in the first place.” In a recent conversation, Dr. Arnold Weinberg, a senior infectious disease specialist at MGH, recalled that when he offered, “Can I fluff your pillow?” to a patient whose pillow had sunken down to the middle of the hospital bed, the patient looked at him with such astonishment and gratitude that Dr. Weinberg said, “I think that simple act made both of our days!”

These small acts of kindness reach beyond making a diagnosis and treatment by relating to patients with humanity and can not only improve physician job satisfaction, but also teach a new generation of trainees how to practice compassionate medicine.

Our hope is that greater empathy will improve the patient experience, reduce physician burnout, and enhance personal satisfaction.

—— Helen Riess, M.D.
For more information, contact Physician Health Services at (781) 434-2404 or www.physicianhealth.org.

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Interim Meeting Deadlines Fast Approaching

The 2012 Interim Meeting of the MMS House of Delegates will be held on Friday and Saturday, November 30–December 1, 2012, at MMS headquarters and the Westin Waltham-Boston Hotel. The deadline for submitting resolutions is Tuesday, October 16. Members may submit resolutions online (preferred method) at www.massmed.org/resolutions or via email to resolutions@mms.org. Members again have the option to post and share their draft resolution online with colleagues for feedback prior to the deadline. Visit http://community.massmed.org/HOD/Home for more details.

There are many events planned during the course of the two-day meeting, including the Seventh Annual Research Poster Symposium, sponsored by the MMS Resident and Fellow and Medical Student Sections. The symposium offers a venue for residents, fellows, and medical students to display their research and compete for cash prizes.

The deadline for submission of abstracts is Monday, October 22. For detailed submission guidelines and more information, go to www.massmed.org/postersymposium or call Colleen Hennessey at (800) 322-2303, ext. 7315.

Monday, October 22, is also the MMS deadline for hotel reservations at the Westin Waltham-Boston Hotel. Please call the hotel directly to make your reservation at 1-800-WESTIN, (800) 937-8461, and ask for the Massachusetts Medical Society group rate. VS

Please visit www.massmed.org/interim2012 for more details about the 2012 Interim Meeting and to register online.
ACROSS THE COMMONWEALTH

District News and Events

Barnstable — Fall District Meeting. Tues., Oct. 2, 6:00 p.m. Speaker: Jeffrey M. Drazen, M.D., editor-in-chief, NEJM. For more information, contact the Southeast Regional Office.

Bristol South — Fall Meeting. Tues., Oct. 2, 6:00 p.m. Location: Fall River Country Club. Speaker: Richard Aghababian, M.D., MMS president. For more information, contact the Southeast Regional Office.

Hampshire/Franklin — Fall Meeting. Thurs., Oct. 4, 6:00 p.m. Location: Blue Heron, Sunderland. Guest Speaker: Richard Aghababian, M.D., MMS president. For more information, contact the West Central Regional Office.

Hampden — Fall District Meeting. Tues., Nov. 27, 5:30 p.m. Guest: Anthony Whittemore, M.D., Topic: When Bad Things Happen to Good Doctors. Location: Baystate Conference Center, Holyoke. For more information, contact the HDMS Office (413) 736-0661 or hdms@mms.org.

Middlesex — Fall Family Jazz/Brunch Event. Sun., Sept. 30. Featuring the River Boat Stompers and brunch from 11:00 a.m. to 1:00 p.m. at Bonaparte, “New England’s Hottest Magician,” from 11:45 a.m. to 12:15 p.m. Location: MMS headquarters, Waltham. Note: Middlesex Executive Committee will meet prior to the event from 10:00 to 11:00 a.m. For more information, contact the HDMS Office (413) 736-0661 or hdms@mms.org.

Middlesex Central — Annual Breakfast. Fri., Oct. 12, 7:30 a.m. Location: Emerson Hospital. Guest Speaker: David Cutler, PhD. 5th Tuesday Program. Tues., Oct. 30, 11:45 a.m. Location: Emerson Hospital. Guest Speaker: Richard Aghababian, M.D., MMS president. For more information, contact the Northeast Regional Office.

Fall Events

A Mentoring Night for Medical Students — The Future of Medicine
TUESDAY, OCTOBER 16 6:30 to 8:00 p.m. MMS headquarters
On October 16, the Massachusetts Medical Society’s Committee on Women in Medicine will host the fifth annual mentoring night for medical students. The goal of this event is to share with students insights on fulfilling career paths in the current practice environment. Kristen Robson, M.D., will serve as the program moderator. A short meeting of the Medical Student Section will follow the program.

Networking Event for LGBT Health Care Providers
THURSDAY, OCTOBER 18 7:00 to 9:30 p.m. Club Café, 209 Columbus Avenue, Boston
A dinner gathering for LGBT medical students and physicians, sponsored by the MMS Committee on Lesbian, Gay, Bisexual and Transgender Matters. There will be a prix fixe menu for $15 per person (includes tax and tip) and a cash bar. To RSVP or learn more about any of these events, contact Erin Tally at etally@mms.org or (781) 434-7413.

IMGs: From Graduate Training to Green Cards
THURSDAY, NOVEMBER 8 6:30 to 8:30 p.m. MMS headquarters
On November 8, the MMS International Medical Graduate Section (IMGS) will host “IMGs: From Graduate Training to Green Cards.” The program will feature immigration attorneys Roy Watson, Esq., and Greg Siskind, Esq., who will address issues such as:
- Screening job opportunities
- Navigating the H-1B Quota
- J-1 Waivers: Conrad and other federal waiver options involving shortage areas and other types of waivers
- Green Card options

Statewide News and Events

Art, History, Humanism, and Culture Member Interest Network — Executive Committee Meeting. Wed., Oct. 3, 6:00 p.m. Location: MMS headquarters, Waltham. Tower Hill Music and Medicine Program. Sat., Oct. 20, 5:30 p.m. Location: Tower Hill Botanic Garden, Boylston. Members are invited to attend the Music and Medicine program being held at Tower Hill Botanic Garden in Boylston. For more information, contact the West Central Regional Office.

If you have news for Across the Commonwealth, contact Michele Jussaume, Northeast Regional Office, at (800) 944-5562 or mjussaume@mms.org; Sheila Kozlowski, Southeast Regional Office, at (800) 322-3301 or skozlowski@mms.org; Cathy Salas, West Central Regional Office, at (800) 522-3112 or csalas@mms.org.

Call for Nominations

2013 Senior Volunteer Physician of the Year Award
Do you know a senior physician who has dedicated their time to volunteering their medical expertise? Nominate him or her as the 2013 MMS Senior Volunteer Physician of the Year.

Criteria:
- MMS member, 60 years of age or older
- Demonstrated commitment to medical volunteerism in Massachusetts

To nominate a senior volunteer physician for this award, please contact Carolyn Maher at cmaher@mms.org or (800) 322-2303, ext. 7311. The deadline for submitting nominations is Thursday, November 1, 2012.

IN MEMORIAM

The following deaths of MMS members were reported to the Society in August 2012. We also note member deaths on the MMS website at www.massmed.org/memoriam.

James S. Abercrombie, M.D., 83; Brookline, MA; University of Arkansas School of Medicine, 1951; died May 3, 2012.

George G. Breit, M.D., 94; Lenox, MA; Middlesex University School of Medicine, 1943; died March 14, 2012.

William J. Brown, M.D., 93; Natick, MA; University of Iowa College of Medicine, 1943; died May 23, 2011.


Nicholas J. Finnara, M.D., 99; Belmont, MA; Boston University School of Medicine, 1939; died June 29, 2012.

David L. Freeman, M.D., 69; Newton, MA; Harvard Medical School, 1969; died July 8, 2012.

Conrad Lüttner, M.D., 81; Peabody, MA; Tufts University School of Medicine, 1956; died March 19, 2012.

Leonard J. Robinson, M.D., 88; Boca Raton, FL; Harvard Medical School, 1949; died March 30, 2012.

Tadeusz S. Stefanski, M.D., 94; Lenox, MA; University of Massachusetts Medical School, 1943; died March 14, 2012.

Raymond F. Zickl, M.D., 72; Norwood, MA; Georgetown University School of Medicine, 1966; died May 22, 2012.
Historic Payment Reform Law Signed

Massachusetts Governor Deval Patrick was joined by legislators as he signed the state’s new payment reform bill into law on August 6, 2012. More on the changes in this month’s Vital Signs cover story, “Managing the New Realities of Care in the Commonwealth.”