

# VITAL SIGNS



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VOLUME 17, ISSUE 8, OCTOBER 2012

## 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

*continued on page 4*

## 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



Photo by Jim Cozzens, HCAM-TV

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.

## PRESIDENT'S MESSAGE



### 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 medical 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 tell us about your experiences in this ever-changing health landscape. Our effective advocacy would not be possible without your support.

*Richard V. Aghababian*

— Richard V. Aghababian, M.D.

### Realities of Care

*continued from page 1*

Meanwhile, Dr. Mills and other physicians have a set of suggested marching orders via the state's "Roadmap to Reform," but little by way of definitive answers to how her practice may be affected by its provisions.

"In a global payment system with an unpredictable group of patients, such as many of those on subsidized health care plans, will global payments adequately cover legitimate expenditures?" she asked. The unknowns are almost endless: "Is it possible that a small private/solo practice such as mine will be able to supply the necessary infrastructure to manage high-risk patients in a capitated model? How much additional administrative burden will I have? Will that further limit my time for direct patient contact?"

### Integration and Consolidation Will Keep Market in Flux

One thing those on the front lines of providing health care express more certainty over, however, is that Massachusetts will continue to see more integration and consolidation of health care systems and their providers. The certification processes for accountable care organizations (ACOs) and patient-centered medical homes (PCMHs) established by the law, for example,

will help carry on what's already been a steady drumbeat toward less-fragmented care, according to Lynn Nicholas, president and chief executive officer of the Massachusetts Hospital Association (MHA).

Already, out of the 80 individual hospital members of MHA, Nicholas noted, only 22 are currently independent and not in a system that involves at least one other hospital. "More of those discussions will be happening," she said. "You will have more integration of care throughout the continuum of care with providers of all types really, truly partnering in a more formal fashion to provide care."

But as with any change, it's unlikely to occur without some growing pains. Physicians and organizations are on the lookout for relationships that will be win-win, Nicholas said. "So as people are trying to negotiate the best way to do this that rewards them financially but at the same time improves care and creates more efficient care, there will be a lot of movement. Relationships will change," she added. "I think there's going to be a lot of flux in the health care market in Massachusetts for the next few years as it settles out."

### Less Experienced with Risk May Struggle

And while risk-based payments are hardly new, there is an enormous range of experience with them among provider groups, according to Elizabeth C. Malko, M.D., executive vice president and chief medical officer of Fallon Community Health Plan (FCHP). "We have a long history of working in risk-based relationships or alternative-pay relationships. It really is part of FCHP's

DNA," she said. "The challenge we have is there are groups who are far ahead of what the bill envisioned, who are already acting as ACOs, and there are groups who haven't even contemplated it. The bill feels a bit one-size-fits-all. There don't seem to be a

*"If people don't work together, this could be ugly. If we do work together, then in three to five years we could see some good, positive change."*

— Elizabeth C. Malko, M.D.

whole lot of tools built in to help those providers who really aren't there," Dr. Malko said.

For groups to be successful under these models, it takes a lot of work, Dr. Malko said. "That's the worry point. This is a very, very short timeframe for providers to move from fee-for-service into accountable care or alternative-pay type of relationships, and do it without building that other set of skills: care management/case management capability and building the individual provider reimbursement methodology that supports good, quality care and cost-effective care," she said.

### Physician Leadership, Collaboration Critical

When it comes to the cost-reduction goal of Massachusetts' reform bill in general, Jeanette Clough, president and CEO of Mount Auburn Hospital in Cambridge, recognizes the need to arrest the soaring costs of health care. "The cost growth has been quite substantial across the country, and Massachusetts is no

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**Realities of Care** *continued*

exception,” she said. “As a result, that has a detrimental effect on businesses and employers, which of course include hospitals, and others who are paying the price.”

But while the idea of sticking to a budget has always been part of running a hospital, Clough noted that there are numerous fiscal factors, such as health plans’ negotiated sums, beyond a hospital’s control. Nonetheless, Mount Auburn is among the hospitals more experienced with working in fixed budgets, according to Clough. “We’ve been doing that on the commercial side, and now we’re more frequently doing it with federal and state payers.”

Part of what helps the hospital succeed in trimming waste and keeping quality, she said, is a highly engaged team of physicians. “There are numerous things physicians would love to do, but you can’t do everything anymore,” she said. “I’m very fortunate here that we have incredible physician leadership. It’s been easier for me to present the facts for physician-leaders and have them respond.”

Hospitals that are similarly experienced will have an advantage as the law is implemented, Clough said, but will still face steep challenges in adhering to the law’s fairly rigid guidelines for the growth of expenses. “Keep in mind that while we’re trying to do this, we have real expenses that are going up,” she said, adding that increased chart auditing and other administrative expenses create yet another burden.

Despite uncertainties about how the lofty goals of the bill will translate into reality, the experts who spoke with *Vital Signs* expressed hope that it will succeed. And even while many physicians, health plans, and other players are still digesting the bill and all it entails, insiders predict that collaboration will be critical. “There has to be flexibility from governmental entities, and we have to work together,” Dr. Malko said. “If people don’t work together, this could be ugly. If we do work together, then in three to five years we could see some good, positive change.” **VS**

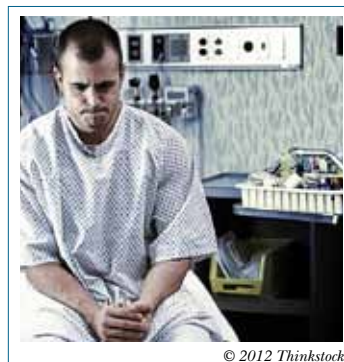
## Affordability is Top Issue for Both Healthy and Sick Massachusetts Residents

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



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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](http://www.bluecrossfoundation.org). The MMS “Patient Access to Care” study can be accessed at [www.massmed.org/patientaccess](http://www.massmed.org/patientaccess). **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

## Ballot Questions

continued from page 1

wish to share the materials with their patients.

The MMS will inform members of their availability online via a notice in *Vital Signs This Week*, and through our regular social media channels.

The materials will be available to the rest of the membership, as well as the general public, on the MMS website. **VS**

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



**Speaker:**  
Siddhartha Mukherjee, M.D., assistant professor of medicine at Columbia

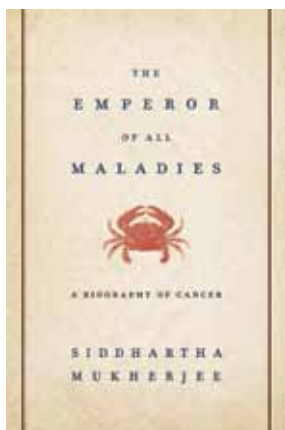
University and an oncologist at the Columbia University Medical Center. He is the author of *The Emperor of All Maladies: A Biography of Cancer*, which won the 2011 Pulitzer Prize for General Nonfiction.

**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](mailto:rvogel@hms.harvard.edu).



## 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 households is critical for the protection of every newborn.

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).



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- 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.

### 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 household 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](http://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.



## STATE UPDATE

## 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. Many of the Society's recommendations are reflected in the final bill, including the requirement that the DPH "automatically and without further action by the registrant enroll all licensed prescribers in the program when the registrant is obtaining or renewing a state controlled state substance permit." The MMS will continue to be active in this important area as we move into regulations to implement the legislation.
- **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. **VS**

— William Ryder

## FEDERAL UPDATE

## 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. **VS**

— Alex. Calcagno

## PHYSICIAN HEALTH MATTERS

## Teaching Empathy Can Improve Patient Satisfaction

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 on 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 resident physicians. 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](http://www.physicianhealth.org).

## 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](http://www.massmed.org/resolutions) or via email to [resolutions@mms.org](mailto: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](http://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](http://www.massmed.org/interim2012) for more details about the 2012 Interim Meeting and to register online.

## 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](mailto: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

## 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](mailto:cmaher@mms.org) or (800) 322-2303, ext. 7311. The deadline for submitting nominations is Thursday, November 1, 2012.

## 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](mailto: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. and Bonaparté, "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 Northeast Regional Office.

**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.

**Middlesex West — Fall Meeting.** Wed., Oct. 10, 6:00 p.m. Location: Hopkinton Country Club. Speaker: Jeffrey M. Drazen, M.D., editor-in-chief, NEJM. Topic: Two Hundred Years of Medical Advances. For more information, contact the Northeast Regional Office.

**Suffolk — District Meeting.** Thurs., Oct. 18, 6:00 p.m. Location: Massachusetts General Hospital, East Garden Room. Speaker: James A. Feldman, M.D. Topic: Measuring Quality of Medical Care: The Perils and the Promise. For more information, contact the Northeast Regional Office.

**Worcester — New England Medical Journal NEJM 200.** Thurs., Oct. 11, 5:30 p.m. Location: Mechanics Hall, Worcester. Speaker: Jeffrey Drazen, M.D., editor-in-chief, NEJM. *Sponsored by the WDMS Public Relations Committee.* **Medical Education Program.** Tues., Oct. 23, 5:30 p.m. Location: Beechwood Hotel, Worcester. Topic: Update in Obesity Management. Speaker: Florencia Halperin, M.D., medical director, Program for Weight Management, Brigham and Women's Hospital. For more information, contact Joyce Cariglia (508) 753-1579.

### 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 Gardens, 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](mailto:mjussaume@mms.org); Sheila Kozlowski, Southeast Regional Office, at (800) 322-3301 or [skozlowski@mms.org](mailto:skozlowski@mms.org); or Cathy Salas, West Central Regional Office, at (800) 522-3112 or [csalas@mms.org](mailto:csalas@mms.org).

## 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](http://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.

**Janet M. Cogoli, M.D.,** 54; Worcester, MA; University of Massachusetts Medical School, Worcester, 1982; died February 16, 2012.

**Jeannette H. Corwin, M.D.,** 79; Lexington, MA; Harvard Medical School, 1958; died April 27, 2012.

**Nicholas J. Fiumara, 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 Litner, 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.,** 76; Plymouth, MA; New York College of Medicine, 1971; died June 23, 2012.

**Raymond F. Zickl, M.D.,** 72; Norwood, MA; Georgetown University School of Medicine, 1966; died May 22, 2012.



## Historic Payment Reform Law Signed



Photo by Rick Gulla

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."

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MASSACHUSETTS  
MEDICAL SOCIETY

# VITALSIGNS

VOLUME 17, ISSUE 8, OCTOBER 2012

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## MMS SPONSORED AND JOINTLY SPONSORED CME ACTIVITIES

### LIVE CME ACTIVITIES

Go to [www.massmed.org/cme/events](http://www.massmed.org/cme/events) or call (800) 843-6356. Unless otherwise noted, all events are held at MMS headquarters, Waltham.

#### 2012 Schwartz Center Speaker Series: Innovative Approaches to Partnering with Patients

Wednesday, Oct. 3, 5:30 p.m. to 7:15 p.m. The Inn at Longwood Medical, Boston

#### Federal Funding Opportunities

Thursday, Oct. 18, 3:00 p.m. to 6:15 p.m. Harvard Medical School, Boston

#### MSCO 2012 Annual Meeting: Burkitt's Lymphoma: From Uganda to U.S. a Personal Journey

Thursday, Nov. 8, 5:30 p.m. to 8:30 p.m. Hilton Boston/Dedham, Dedham

#### CME Accreditation Orientation

Tues., Oct. 16, 8:30 a.m. to 11:45 a.m.

#### Controversies in the Screening and Management of Breast Disease

Wed., Oct. 24, 8:00 a.m. to noon

#### Managing Workplace Conflict

Thurs., Nov. 1, 8:00 a.m. to 4:00 p.m., and Fri., Nov. 2, 8:00 a.m. to 3:00 p.m.

### SAVE THE DATE

#### Federal Funding Opportunities

Thurs., Oct. 18, Harvard Medical School, Boston

#### Directors of Medical Education Conference

Thurs., Nov. 8

### ONLINE CME ACTIVITIES

Go to [www.massmed.org/cme](http://www.massmed.org/cme).

#### Risk Management CME

#### End Of Life Care

- The Importance of Discussing End-of-Life Care with Patients\*
- The Unintended Consequences of DNR Orders\*
- Legal Advisor: Advance Directives\*

#### Pain Management

- Legal Advisor: Identifying Potential Drug Dependence and Preventing Abuse\*
- Managing Risk When Prescribing Narcotic Painkillers for Patients\*

#### Other Risk Management CME

- Breast Cancer Seminar Series OnDemand
- Legal Advisor: Legal Duties and Options when a Patient Raises Suicide

- Incorporating Meaningful Use in the Specialty Practice
- Acid Suppression Therapy: Neutralizing the Hype
- The Importance of Data Analytics in Physician Practice
- Seven Steps to Better Health Literacy\*
- A Path to ACOs
- The Changing Nature of Informed Consent

\* Also available in print. Call (800) 322-2303, ext. 7306.

Risk Management  
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