

VITAL SIGNS



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VOLUME 18, ISSUE 2, FEBRUARY 2013

Payment Reform, Access Issues Top Physicians' Concerns for 2013

BY DEBRA BEAULIEU

Vital Signs asked several members to share their top professional concerns of the moment, as well as the fundamental reasons they look forward to practicing in 2013 and beyond.

Payment Reform

Now that the provisions laid out in Chapter 224 have become law, implementation questions are high on physicians' minds going into 2013.

"Payment reform is going to be huge," said MMS President Richard V. Aghababian, M.D. "But the question is, 'Will there be funding for all the pieces [legislators] put in there or not?'"

Meanwhile, health care organizations and insurers continue to digest the bill, leaving physicians uncertain. "This is going to be a year in which a lot of people are

going to be trying to figure out how to best position their practices for the coming changes in payment systems," said Thomas C. Hines, M.D., assistant professor and residency director at Boston University Medical Center (BUMC) and immediate past president of the Massachusetts Academy of Family Physicians. "There's a several-year ramp-up, but this is going to be a crucial year."

Choosing the Right Practice Model

Aghababian agreed, noting that physicians may look at these decisions differently depending on their stage of practice. Newly trained doctors, in particular, are likely going to have big choices to make about whether to choose private practice, group practice, or hospital employment. "But you've got to pick the right terms and conditions to suit you, and

that will allow you to achieve your other goals outside of medicine" he said.

Because of the need to educate physicians at all career stages about such issues, the Massachusetts Medical Society updated its Model Physician Employment Contract in October, available as a free download for members at www.massmed.org/employed.

Addressing Access Issues

Factors driving demand for physicians — near-universal health insurance coverage coupled with severe physician shortages — also put patients' access to physicians at risk. The problem plagues all specialties, but it's one that hits mental health patients in Massachusetts particularly hard, according to Donald Condie, M.D., a psychiatrist and clinical instructor at Massachusetts General Hospital.

"In general, the issue is that resources for mental health were cut during the recession, and that's exactly the same time when more resources were needed," he said. Dr. Condie noted access to psychiatric care in Massachusetts, especially for children, is extremely difficult.

Another pressing issue for the coming year is the need to more closely integrate mental health with pediatric care and internal medicine, Dr. Condie said. Although the start date has been delayed several times, changes are in motion to better integrate care for dual-eligibles, adults who are eligible for both MassHealth and Medicare.

Integrated care organizations (ICOs), six of which have been preliminarily accepted in the Commonwealth so far, are

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White Coats and iPhones: Mobile Technology

Part Two of a Vital Signs Series on Physicians and Technology

BY VICKI RITTERBAND

While a growing number of physicians are using their mobile devices to access their EHRs, there are still some inherent obstacles to overcome. One is that because many EHR vendors haven't yet come out with native versions of their products for smartphones and iPads, the user experience isn't always optimal. And even when an EHR company has developed mobile applications for its system, you're still bumping up against the physical limitations of the device — namely

screen size and the lack of a keyboard.

"Tablet computers like iPads are very useful for reviewing information, but it's hard to fully document and order without using a keyboard, which is why I use a laptop/tablet combo device and why the iPad users in my office use a Bluetooth wireless keyboard," said Michael Lee, M.D., director of clinical informatics at Atrius Health and a pediatrician with Dedham Medical Associates. "But then, adding

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Dr. Carole Allen Appointed to Health Policy Commission



Photo courtesy of Axel Del Cid & Eric Haynes/Governor's Office

Governor Deval Patrick congratulates newly appointed members of the Health Policy Commission Board, including Brandeis University health policy professor Stuart Altman, Ph.D., (center) and retired Arlington pediatrician Dr. Carole Allen, M.D. (right). See Page 5 for a Vital Signs interview with Dr. Allen.

PRESIDENT'S MESSAGE



Acts of Violence: A Call to Action

In the wake of the tragic school shootings in Newtown, Connecticut, I believe that it's imperative that physicians and the Massachusetts Medical Society take action.

As always, we must focus on the safety of our patients, children, and communities. But we need to do more than that; it is time for us to speak out. As part of our action, I have asked that the MMS focus on three areas: gun control, mental health, and education.

We should review our gun policies to see if there are opportunities for improvement, based on what we have learned from recent disasters. For example, we should support reforms that limit access to assault weapons and large clips of ammunition.

At the same time, we must advocate for meaningful changes in mental health care. Meaningful change must include society as a whole giving the same attention to mental illness that it does to physical illness. We should be increasingly sensitive to early identification of those individuals who may be prone to outbreaks of violence.

Our annual Public Health Leadership Forum in April will focus on mental health, address the current mental health system, and how to work together to better address patients' needs.

As always, we will work with our health care partners across the state in order to best protect our patients and our communities.

I urge you to stay connected on this issue. If you have suggestions on directions we should pursue, please contact me at president@massmed.org.

Richard V. Aghababian

— Richard V. Aghababian, M.D.

Mobile Technology

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keyboards reduces the easy portability of the devices."

Some physicians also worry about the distraction factor, when sending an order or a prescription, for example, gets interrupted and possibly forgotten if a text from a friend pops up on their screen. "This generation of 20-somethings grew up on social networks and being completely connected. And they believe that they can be effective when multitasking," said John Halamka, M.D., chief information officer at Beth Israel Deaconess Medical Center (BIDMC) and an emergency physician. "How many studies do we need to realize that texting while driving is worse than drinking while driving? Doctors need to separate their personal networking activities from their health care activities because it's a risk."

Security Concerns

Of even greater concern to hospitals and practices is the security of patient information on mobile devices. Dr. Halamka, one of the country's most well-known health care technology gurus, is a huge advocate of mobile technology, but knows better than anyone its attendant risks. In May 2012, a physician's personal laptop computer was stolen from a BIDMC office, raising concerns that some patients' personal health information may have been compromised.

While BIDMC has always required employees to encrypt their devices, set a password, and refrain from storing patient information on them, enforcement was once difficult, if not impossible. The incident spurred the hospital to set up depots where employees were required to drop off their devices for encryption and inspection for malware and vulnerabilities. This gives the hospital the ability to ferret out unsecured devices.

"When staff connect their device to our corporate server, we have technology that checks for passwords and encryption — enforcing the policy," said Dr. Halamka. "They have to 'announce' who they are and that they are appropriately secure. The technology to do this only matured in 2012." Additionally, after 10 unsuccessful log-ins to a BIDMC staffer's phone, tablet, or laptop, the entire device is auto-wiped. "That's one of the reasons I'm so unpopular," quipped Dr. Halamka. **VS**

Putting Mobile Devices in the Patient's Hands

The Center for Connected Health's diabetic patients hook up their home glucometers to a device that looks like a cell phone. The gadget automatically sends their readings to the EHR, and outlier values are flagged by the software for follow up. Cardiac patients have their blood pressure, pulse, oxygen levels, and weight monitored electronically from the comfort of their homes. And pregnant patients receive regular text messages on their phones with week-specific information and reminders.

"As we move from a payment model which reimbursed per transaction to reimbursement for global care, it starts to change the way we think about using our resources, especially the office," said Joseph Kvedar, M.D., director of the center, which is a division of Partners HealthCare. "We're the only service left on the planet where we demand you physically visit us to have a service delivered."

Leveraging the power of mobile technology on the patient side of the doctor-patient relationship is one way to realize the promise of the patient-centered medical home, a model that emphasizes keeping people well. The Center for Connected Health has the data to prove its remote monitoring programs do just that. "Readmission rates have been lowered by 50 percent for our heart failure patients and our diabetics have decreased their HbA1c levels by an average of 1.5 points," said Dr. Kvedar.

Dr. Kvedar understands that many physicians will be unwilling to bear the cost of telemonitoring equipment, which is why he is a big advocate of texting programs.

"You don't need fancy infrastructure and it's easy to implement and scale," he said.

Harvard Vanguard Internist Chloeanne Georgia, M.D., has another way of using mobile technology to engage patients: simply recommending smartphone applications that she has tested herself, including ones that track caloric intake, exercise, and menstrual periods. And she won't recommend an app unless it's free.

"Patients interact with their phones every day, so this is a good reminder that they should take care of themselves every day too," said Dr. Georgia. "They're participating in their own care and doing something proactive."

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LAW AND ETHICS

Mass. Physician Gift Ban Relaxed

In July, Massachusetts Gov. Deval Patrick signed the Commonwealth's FY 2013 budget, which included legislation that amended the Massachusetts Pharmaceutical and Medical Device Manufacturer Code of Conduct, the so-called physician gift ban. These amendments eased some of the more contentious restrictions of the physician gift ban and will likely have a significant effect on interactions between industry and health care providers in Massachusetts.

Under the original physician gift ban law, pharmaceutical and medical device manufacturers were prohibited from providing meals for health care practitioners outside of the office or hospital. Now, pharmaceutical and medical device manufacturers are permitted to pay for "modest meals and refreshments" for health care practitioners in certain situations outside of the office or hospital setting. On November 21, 2012, the Massachusetts Department of Public Health (DPH) approved the final regulations, implementing the changes to the physician gift ban in accordance the FY 2013 budget legislation and providing clearer guidance on the matter.

The amended regulations state that pharmaceutical or medical device manufacturers may provide or provide payment for modest meals and refreshments to health care practitioners outside of the health care practitioner's office or hospital setting if: (1) the meal is provided for the purpose of educating and informing health care practitioners about the benefits, risks, and appropriate uses of prescription drugs or medical devices, disease states, or other scientific information, and (2) such presentations occur in a venue and manner conducive to informational communication. DPH further defines modest meals and refreshments as food or drinks that "as judged by local standards, are similar to what a health care practitioner might purchase when dining at his or her own expense."

The recent legislation also relaxes some of the reporting requirements for pharmaceutical and device

A recent survey of young physicians in Massachusetts conducted by the MMS's Health Policy and Health Systems Department revealed important trends. The study found that young physicians chose to remain in the state for several distinct reasons, including the academic environment and local family ties. The MMS survey also revealed needed areas of improvement in both the practice and education of young physicians.

The study of recent residents and new physicians sought input from both young physicians and local residency and fellowship program directors regarding practice decisions and needs in their first few years as a physician.

Of the nearly 50 young physicians surveyed, the majority chose to remain in Massachusetts, most commonly because of family ties in the state and the vibrancy of the academic and medical environment.

Thirty-nine percent of the young physicians characterized their medical practice type as part of a hospital system or

manufacturers, eliminating redundancies, and permitting disclosures already required under the Federal Sunshine Law to the U.S. Department of Health and Human Services to satisfy some of the DPH requirements. These changes to the reporting requirements, coupled with the allowance for modest meals outside the office and hospital settings, are intended, in part, to reduce uncertainties faced by pharmaceutical and medical device companies when sponsoring local and national meetings and conferences attended by Massachusetts physicians. **VS**

—William Frank, Esq.

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

Despite Debt and Housing Costs, Young Physicians Choose Mass.

Choices Reflect Strong Practice Environment, Family Proximity

network, while only 15 percent worked as part of a clinically integrated delivery system such as an accountable care organization (ACO). Interestingly, while the physicians knew how they were employed, 59 percent did not know if they were reimbursed through the use of global budgets.

"Without a doubt, the trend is toward employment for young physicians," said Spiro Spanakis, D.O., chair of the MMS Committee on Young Physicians.

For young physicians who chose to practice out of state, family reasons were also a main factor in their decision to leave Massachusetts. Some also relocated simply because they were able to find academic teaching positions elsewhere.

Program directors concurred that the living environment in Massachusetts, while desirable, is often cost-prohibitive for young trainees. Following the completion of training, the average medical school graduate enters the workforce with more than \$161,290 in educational debt,

and then faces a housing market where the average single family home costs \$277,000.

A number of the program directors in the MMS survey said new physicians needed more education on basic but important issues of being a young physician, such as learning medical business skills, navigating student loan debt, and working with the housing market.

Young physicians expressed a need for more education regarding how payment reform will affect their practice and their role within new health care systems.

"Understanding how we fit within the whole health care system and work with these changes will be key," said Spanakis. Ultimately, understanding young physicians' choices and learning priorities will be important for the future success of the health care system. **VS**

—Leif Brierley

MMS members are welcome to join the Young Physicians Committee. If interested, please email chennessy@mms.org.

Payment Reform

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intended to provide dual-eligibles a broad range of medical and behavioral health services.

According to Dr. Condie, these changes offer hope to improve on some of the current system's flaws. "[ICOs] will still have to demonstrate to the state that they have the capability to provide integrated services for this [dual-eligible] population, who are the really most vulnerable people, and very much need better integrated care," he said.

Reasons for Optimism

Although no one can predict exactly what the future holds, the physicians we spoke to expressed reasons to be optimistic.

"I think it's pretty positive that just about everyone in the state will have health insurance," Dr. Aghababian said. "There's no excuse for people to not get medical care. And there's no excuse for people not to maintain their own wellness."

Other positives are as old as the practice of medicine itself. "I have to admit that as somebody who's been in family medicine for 30 years, what continues always to sustain me is the relationships I've built with my patients over the course of that time," said BUMC's Dr. Hines. "And so what I'm looking forward to is the opportunities the coming year are going to present for me to help maintain and foster those relationships and help improve the lives of my patients." **VS**

MOLST Expands Statewide

Thirty hospitals across the state are preparing to launch MOLST (medical orders for life-sustaining treatment), and 80 of the state's 400 nursing homes have begun MOLST implementation, said Mary Valliere, M.D., MOLST expansion medical consultant. Home health and hospice agencies are also moving into the implementation phase, with a target completion date of January 2014.

MOLST, legally valid across participating institutions, contains a clinician's written instructions about end-of-life care based on the patient's preferences. MOLST forms are only designed for patients with advanced illness. "It's different from a health care proxy, which everyone 18 and older should have," said Dr. Valliere.

"Talking about death and end-of-life care has always been challenging — for doctors, for patients, and for families," said Beth Warner, D.O., medical director of Cooley Dickinson's geriatric services and member of MMS's Committee on Geriatric Medicine. "Using the MOLST form as a tool can help focus the discussion, tailor it to each individual, and translate patient wishes into actionable orders. We can then outline wishes that we have

not been able to capture with the DPH comfort care/DNR, such as 'use intubation and ventilation, but short-term only' with the expectation that these orders will be honored by emergency providers and reviewed based on changing clinical scenarios and patient preference."

The MOLST project in Massachusetts began after a 2008 mandate and is modeled after projects implemented in other states.

A collaboration of Commonwealth Medicine, the DPH, and the state's office of elder affairs, the program works with institutions to implement policies, procedures, and training. Institutions are asked to inform physicians in the community once their MOLST program is in place.

Dr. Warner recommends that every physician know how to recognize, honor, review, and void MOLST forms, and that those who are involved in advance care planning discussions should explore the MOLST website and begin preparing to use the forms with patients. Training modules and checklists for physicians, as well as information for patients, can be found at www.molst-ma.org. **VS**

— Robyn Alie

State Seeks Physicians

PERAC Disability

The Public Employee Retirement Administration Commission (PERAC), which schedules medical panel examinations for public employees, is recruiting Massachusetts board certified cardiologists, oncologists, pulmonary specialists, orthopedists, and others to examine individuals who have applied for, or are receiving, disability benefits from one of the Commonwealth's retirement systems. Physicians will perform objective evaluations to determine disability, permanency, and causality. Physicians may also be asked to evaluate disability retirees seeking to be restored employment. Physicians interested in conducting medical panel and/or restoration-to-service examinations for PERAC should contact Kate Hogan, manager of medical records, at (617) 591-8949.

Impartial Examiners

The Massachusetts Department of Industrial Accidents (DIA) is seeking qualified, board certified physicians to serve as impartial medical examiners for cases involving injuries and illnesses sustained by workers. When there is an appeal of a judge's conference order in a dispute regarding a medical issue, an impartial medical examiner examines an injured worker and renders a written report regarding causation and disability. The DIA is particularly seeking orthopedic surgeons, neurologists, neurosurgeons, and internists specializing in pain management. More information and an application form can be found at www.mass.gov/lwd/workers-compensation.

Naloxone Reverses Opioid Overdose

MMS Encourages MDs to Prescribe

From 1990–2006, Massachusetts saw a 600 percent increase in deaths from opioid overdose. "The statistics are pretty striking," said David Stahl, M.D., chair of the MMS's Resident and Fellow Section. "They outpace deaths from motor vehicle accidents."

Dr. Stahl recently sponsored a resolution to the MMS House of Delegates urging MMS action on the issue. MMS policy, adopted in December, encourages appropriate prescription of nasal naloxone for patients at risk for opioid overdose.

Administering naloxone during an opioid overdose reverses the overdose entirely, often preventing death. Several community based programs around the country have implemented nasal naloxone programs. Since 2007, the Massachusetts DPH has provided overdose prevention training and nasal naloxone to over 15,000 participants, yielding more than 1,500 successful overdose rescues.

Last August, Massachusetts law was amended to allow for the prescription and dispensing of naloxone to a person at risk of experiencing an opiate-related overdose or to a family member or other person in a position to assist such a person.

"As an anesthesiologist, I feel very comfortable with naloxone as a medication," said Dr. Stahl, who has noticed that anecdotes about bad reactions to naloxone have caused some misunderstanding and fear among physicians. "In fact," said Dr. Stahl, "safety studies show that it does not cause seizures or pulmonary edema; it's usually the opioids that cause that." Naloxone has no abuse potential, and its only contraindication is a prior allergic reaction, which is rare.

Additionally, there's no data to indicate that access to naloxone will increase opioid use. Data demonstrate that similar harm-reduction efforts — condom distribution or needle exchange programs — increase healthy behaviors.

Dr. Stahl encourages physicians to consider a naloxone

prescription for people who have had emergency medical care for opioid overdose in the past, those who admit to recreational opioid use, people who have been prescribed methadone or buprenorphine, and those who use greater than 50mg morphine equivalents per day.

Discuss Naloxone When Prescribing Pain Meds

Alexander Walley, M.D., MSc, an internist at BMC and medical director of the state's opioid overdose prevention pilot program, says that physician prescribing of naloxone is particularly important for preventing overdoses in prescription opioid users who may or may not be addicted. "When physicians prescribe pain medication, the conversation needs to include prevention and how to prepare for an adverse event," said Dr. Walley. "By talking about their risk, and how to prevent and reverse an overdose, we let them know this needs to be taken seriously."

Not all pharmacies currently carry nasal naloxone and the atomizer required to administer it. Once physicians start prescribing it, Dr. Walley thinks more pharmacies are likely to stock it. He suggests physicians contact a local pharmacy to see if they stock it, and if not, encourage them to do so. The law allows for the prescription of either nasal, or intramuscular naloxone, which is more readily available. A physician or pharmacist can show the patient how to administer the naloxone.

For more guidance, visit the "prescribe" tab on the website, www.prescribetoprevent.org, compiled by naloxone advocates, including Dr. Walley. The website also includes links to training videos for consumers. The state's Bureau of Substance Abuse Prevention provides recorded information on how to prevent, recognize, and respond to an opioid overdose at (800) 383-2437, as well as a list of naloxone dispensaries at (800) 327-5050. **VS**

— Robyn Alie

STATE UPDATE

An Interview with Dr. Carole Allen

Vital Signs caught up with Carole Allen, M.D., in December, shortly after her second meeting as a member of the Commonwealth's newly formed Health Policy Commission. Governor Deval Patrick appointed Dr. Allen to the commission, filling a slot devoted to a primary care physician. Dr. Allen is recently retired after 37 years as a pediatrician, serving in a health center, private practice, and as the director of pediatrics for Harvard Vanguard. She has a strong history of advocacy and work in organized medicine, including leadership on tobacco and LGBT issues and through participation in the MMS's House of Delegates, Board of Trustees, and Committee on Legislation.

Prepared to Serve

The Health Policy Commission is a major new entity created by last year's Chapter 224, a 349-page comprehensive payment reform law passed in July. The Commission is tasked with many new responsibilities and will be

funded by an initial \$225 million assessment on state hospitals and eventually funded by gaming revenues.

Its responsibilities include establishing the annual health care cost growth benchmark; examining the impact of changes on providers and access; overseeing ACO development; tracking progress on mental health and substance abuse parity; and developing standards for certification of patient-centered medical homes.

To accomplish these tasks, the commission, chaired by Stuart Altman, Ph.D., has established four subcommittees: Cost Trends and Market Performance; Quality Improvement and Patient Protection; Care Delivery and Payments System Reform; and, Community Health Care Investment and Consumer Involvement. Dr. Allen has been asked to coordinate the formation of the Quality Improvement and Patient Protection group.

Dr. Allen said she prepared to serve by reviewing materials from

a variety of sources, allowing her to bring an informed perspective to the decision-making process.

"I've read the various analyses of the law, including that by the MMS. There is so much in it, but it is a good-faith effort to try to do something about health care costs, but do so in a manner that doesn't take resources from such a huge part of our economy, and in a way that doesn't damage what's good in the system in the name of cost control."

Accountable Care Model

One key task will be the integration of behavioral health care and primary care and particularly of ensuring that patients within an ACO (accountable care organization) stay within the ACO. "A better understanding of our patients, and support for outreach to keep patients in the system, are essential for the accountable care model to work. A small practice can follow patients and there is a smaller likelihood of their exercising their options of freely seeking services outside the ACO."

The emphasis has to be on quality improvements first and reduced costs second, she said.

"Hospital discharge systems should have support for outreach to ensure that care transitions take place in a manner that coordinates care leading to improved outcomes, and thereby leads to reduced costs," said Dr. Allen.

Dr. Allen's solid knowledge of federal pediatric initiatives will be invaluable in her work on the council. She said she is seeking to find the nexus between health care and education for children, or the increased role the local boards of health may play in reinforcing the positive lifestyle changes recommended by primary care providers.

Dr. Allen brings a strong commitment to patients and deep experience with a variety of health care systems. The MMS is pleased to have in her in this important position and commends her for volunteering her time and energy to this difficult and complex endeavor. **VS**

— William Ryder

FEDERAL UPDATE

Federal Fiscal Crisis Temporarily Averted

In its last act, the 112th Congress barely averted the full ramifications of looming fiscal cliff. The American Taxpayer Relief Act stops the pending 27 percent SGR cuts and extends current Medicare physician payments rates through December 31, 2013.

The law also:

- Defers sequestration cuts for two months, including the 2 percent cut in Medicare payments and larger program cuts for other health programs (e.g., research/public health/health professions training)
- Extends the 1 percent Geographic Work Adjustment for rural providers through December 31, 2013
- Includes provisions to create a path to improve the provision of relevant and timely data to

physicians, needed in new delivery and payment models (provisions which the AMA helped frame in bipartisan negotiations with Senate Finance Committee staff)

- Allows physician participation in clinical registries to meet Medicare quality reporting requirements (provision which AMA also helped frame in bipartisan discussions with Senate Finance staff)
- Provides one-year reauthorization of funding for National Quality Forum

The \$25 billion cost for the SGR patch alone, as well as additional expenses for other Medicare extender provisions, were offset by a number of health care reductions, including cuts in Disproportionate Share Payments to

hospitals and cuts to imaging services. Proposals to eliminate the increase in Medicaid payments for primary care services and remaining funds for prevention (ACA provisions) were not adopted.

Other offsets included extending the statute of limitations from 3 to 5 years for recoupment of overpayments and elimination of unobligated funds for health insurance co-ops authorized by the Affordable Care Act. Existing obligations to health insurance co-ops will be honored. A summary of the major health care provisions and the related offsets are detailed at www.massmed.org.

All members of the Massachusetts congressional delegation voted in favor of the bills.

The 113th Congress will now be charged with the daunting task of developing long-term Medicare and Medicaid reforms — both to avert sequestration and to prevent a repeat of last year's deficit ceiling debacle. The AMA, MMS, and other national and state medical organizations are working on recommendations to help frame these negotiations and promote payment reform which incentivizes high quality, cost efficient health care.

We look forward to continuing our work with our congressional delegation, patients, and medical and health care colleagues as we enter this new legislative session. **VS**

— Alex. Calcagno

PHYSICIAN HEALTH MATTERS

The Power of Peer Support: A PHS Client Tells Her Story

"My name is Darleen. I'm an internist and I have no idea why I am here. I'm doing just fine and I have nothing to report to the group."

That is how I signed in at my first PHS group meeting. Seven years and 150 meetings later, I know exactly why I was there and that I was anything but fine. On that Wednesday night, I walked into a room full of doctors sitting around a table, quietly welcoming me as a new member.

I was convinced, or so I thought with a dose of arrogance and conviction, that my being there was a big

mistake. *Don't people know who I am? I'm a doctor! I do not need anyone's help. I give help.* Little did I

know, the only thing I did have was a total and profound lack of insight into my situation. So, I told my story and gave all the reasons why I did not belong there. I rounded up all the usual suspects (i.e., my boss, other doctors, nurses, administrators, HR, patients) and fired at them as best I could. While I was pointing my finger at them I did not see the other three fingers on my hand pointing right back at me.

A few meetings later, I found myself all alone on the battlefield without anybody left to fire at but myself. At that moment I knew it was all me, my problem and the solution all wrapped up in one. That was the moment I fell apart and began to heal while the group stood by to catch me and give me support. I was on my way.

Later on, I was on standby, waiting to catch and offer support to other fallen heroes. That's what we do here. We are all in it together — the only thing we have in common is the language we speak, and I do not mean English. That is our own doctors' language understood by us doctors only. That is the healing power of the group. That is our secret weapon.

Problems at work or our personal difficulties that brought us to the group are as diverse and colorful as we are. We are all smart, educated, hardworking, and dedicated people who want to make something of our lives so we can make a difference in others' lives.

We listen carefully, gather information, analyze it in our well-known problem-solving manner; we give support, we offer suggestions, we even offer resolution.

We do not accuse, we do not judge, we do not patronize, minimize, or ignore the problem. We support and give back our tough love and the newcomer feels and understands that love.

The strength of the group becomes apparent when we are able to redirect the focus of the problem from others to ourselves. We learn from each other how to recognize and accept our part in the problem.

The group lets the new doctor point fingers at others at the initial meetings, but then he or she slowly becomes aware of the other three fingers pointing back at him or her. We let the person stand there for a while and we know how extremely painful that moment is. We feel the anger and anguish simmering inside; we have all been there. We are waiting for that transformation, for that insight to come, for that magical moment when we realize that we are the problem and the solution — nothing more, nothing less.

My name is Darleen, and I just want to say how glad I am to have been here for the past seven years and how much happier I am — what a better person and a doctor I have become.

For her full story and more information about the Physician Health Services, Inc., support groups available, please visit www.physicianhealth.org.

"That is the healing power of the group. That is our secret weapon."

Member Benefit Spotlight: The Legal Advisory Plan

The Massachusetts Medical Society offers an exclusive benefit to members called the Legal Advisory Plan (LAP).



What is the Legal Advisory Plan?

The LAP is a legal services plan available only to MMS members. It provides advisory and consultation services for specific Board of Registration in Medicine (BRM) matters for a flat fee of \$70 per year. (Discounts are available when five or more physicians enroll.)

Why should MMS members consider enrolling in this benefit?

Many times a well-crafted letter by an attorney in response to a complaint may be all that is needed to resolve the situation. To hire a lawyer to craft that response can cost up to \$1,000. If you are a member of the Legal Advisory Plan such a letter, for example, is included in your enrollment fee. Representing yourself before the BRM without the benefit of legal counsel can be dangerous. Your license is a valuable asset, and you don't want to find yourself the subject of a complaint without the assistance of the Legal Advisory Plan.

Doesn't malpractice insurance cover complaints and issues before the board?

Unless a complaint before the BRM involves bodily injury, your malpractice insurance may not cover the incident. Disciplinary proceedings or complaints by difficult patients are two examples where the plan would be a benefit.

What other benefits are included?

Additional exclusive benefits LAP members also receive when they enroll in the plan include:

- A free 30-minute consultation with LAP attorneys to discuss difficult patients, BRM regulations, and your legal rights
- A free quarterly newsletter, *The Legal Advisor*, featuring articles on changing laws, BRM decisions, and more
- Online CME component of *The Legal Advisor* newsletters, including courses that meet the new requirements for end-of-life and effective pain management credits

When should I enroll?

Enroll now to start your coverage as soon as possible. The LAP will not cover investigations or proceedings of which you were aware before you enrolled. To download an application for the Legal Advisory Plan, go to www.massmed.org/LAP. VS

Call for Nominations: MMS Officer Positions

The Committee on Nominations is currently accepting nominations for the following offices: President-elect, Vice President, Secretary-Treasurer, Assistant Secretary-Treasurer, Speaker, and Vice Speaker.

To be considered for one of these offices, candidates should complete a nomination questionnaire and submit it with an accompanying resume **by 4:00 p.m. on Friday, February 8**, to the following address:

Frank S. Carbone Jr., M.D., Chair, Committee on Nominations
MMS Department of Governance Meetings and Services
860 Winter Street, Waltham, MA 02451-1411

Candidate questionnaires are available online at www.massmed.org/officernom. E-questionnaires should be emailed to Bonney Erskine at berskine@mms.org.

Interviews will be conducted on Wednesday, March 6, 2013, between 4:30 p.m. and 7:30 p.m.

IN MEMORIAM

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

Malcolm Bick, M.D., 95; Nokomis, FL; Harvard Medical School, 1940; died June 4, 2011.

David A. Browne, M.D., 84; Plympton, MA; University of Virginia School of Medicine, 1955; died July 10, 2012.

Edmund B. Cabot, M.D., 69; Boston, MA; Harvard Medical School, 1972; died September 1, 2012.

Solomon J. Fleishman, M.D., 97; Auburndale, MA; Medical School of Wiltwatersrand, 1938; died September 16, 2012.

David M. Jewett, M.D., 82; Falmouth, ME; Temple University School of Medicine, 1955; died August 5, 2012.

Melvin J. King, M.D., 89; Attleboro, MA; Cornell University Medical College, 1954; died August 6, 2012.

Frank J. Lepreau Jr., M.D., 99; Wakefield, RI; Harvard Medical School, 1938; died January 25, 2012.

Semon M. Lilienfeld, M.D., 91; Jaffrey, NH; New York University School of Medicine, 1944; died March 25, 2012.

John A. Peters, M.D., 86; Scituate, MA; Harvard Medical School, 1954; died June 22, 2012.

Jacob Rice, M.D., 89; Yarmouth Port, MA; Tufts University School of Medicine, 1950; died January 4, 2010.

Samuel R. Schuster, M.D., 90; Westborough, MA; Case Western Reserve University School of Medicine, 1950; died July 29, 2012.

Karl Sorger, M.D., 83; Winchester, MA; University of Graz, 1954; died August 27, 2012.

William J. Thomas, M.D., 79; Hyannis, MA; Jefferson Medical College, 1958; died October 23, 2012.

Robert B. Thompson, M.D., 83; Tyler, TX; University of Western Ontario, 1953; died July 1, 2012.

Robert E. Wise, M.D., 94; Westwood, MA; University of Maryland School of Medicine, 1943; died August 12, 2012.

ACROSS THE COMMONWEALTH

District News and Events

Hampshire and Franklin Districts — UMass Men's Basketball Event. Sat., Feb. 9, 1:00 p.m. Location: Mullins Center, Amherst. For more information, contact West Central Regional Office.

Norfolk — Executive Committee/Standing Committee Meeting. Wed., Feb. 13, 6:00 p.m. Location: MMS headquarters, Waltham. For more information, contact Northeast Regional Office.

Plymouth — District Meeting. Thurs., Feb. 28, 6:00 p.m. Location: Atlantica Restaurant, Cohasset. For more information, contact Southeast Regional Office.

Worcester — 217th Annual Oration. Wed., Feb. 13, 5:30 p.m. Location: Beechwood Hotel, Worcester. Orator: Michael F. Collins, M.D., senior vice president, health sciences, UMass; chancellor, UMass Medical School; and professor, quantitative health sciences and medicine. For more information, contact Joyce Cariglia (508) 753-1579.

Statewide News and Events

Art, History, Humanism and, Culture Member Interest Network — Winter Eagles Program. Sat., Feb. 2, 10:00 a.m. to 1:00 p.m. (Snow date, Sun., Feb. 3) Location: Joppa Flats, Newburyport. For more information, contact 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; or Cathy Salas, West Central Regional Office, at (800) 522-3112 or csalas@mms.org.

MMS Committee Appointments 2013–2014

Deadline for Consideration: March 8, 2013

If you would like to become more involved in the MMS, consider participating on a committee or the Member Interest Network (MIN) Executive Council.

Committee appointments are for specific terms, usually three-year renewable commitments. We have put in place resources for distance participation, including conference calls, online meetings, and video conferencing at regional offices. Those with limited time who wish to participate can take advantage of these means.

The listing below includes all MMS committees and the MIN Executive Council. For committee descriptions and an application form to be considered for a committee, contact Sandra Manchester at the MMS Executive Office via (800) 322-2303, ext. 7012, or email smanchester@mms.org. If you would like to join the MIN Executive Council, contact Cathy Salas at the West Central Regional Office (800) 322-2303, ext. 7715, or email csalas@mms.org.

- Ethics, Grievances, and Professional Standards
- Interspecialty
- Judicial
- Medical Education
- Membership
- Professional Liability (*Standing Committee status pending bylaws approval at Annual Meeting 2013*)
- Public Health
- Publications
- Quality of Medical Practice

Special Committees Appointed by the President-elect

- Accreditation Review
- Diversity in Medicine
- Environmental and Occupational Health
- Geriatric Medicine
- Global Health
- History
- Information Technology
- Lesbian, Gay, Bisexual and Transgender Matters
- Maternal and Perinatal Welfare
- Men's Health
- Nutrition and Physical Activity
- Preparedness
- Senior Volunteer Physicians
- Sponsored Programs
- Student Health and Sports Medicine
- Violence Intervention and Prevention
- Women in Medicine
- Young Physicians

District Appointed Committees

(contact your district medical society for more information)

- Legislation
- Nominations

Member Interest Network (MIN) Executive Council

- Arts, History, Humanism and Culture

Board of Trustees Committees Appointed by the Board

(limited openings in accordance with bylaws)

- Administration and Management
- Finance
- Member Services
- Recognition Awards
- Strategic Planning

Standing Committees Appointed by the President-elect

(limited openings in accordance with bylaws)

- Bylaws
- Communications

MMS Evening Legislative Workshop

On Wednesday, February 6, 2013, the MMS Resident and Fellow Section and Medical Student Section will sponsor a legislative workshop from 7:30 p.m. to 9:00 p.m. in the O'Keefe Auditorium at Massachusetts General Hospital in Boston.

This interactive program will provide attendees with an excellent overview of the latest legislative developments in Washington, D.C., and on Beacon Hill, as well as provide invaluable

training in effective lobbying and honing communication skills.

A light dinner will be provided. This event is free for any MMS member interested in getting involved in legislative advocacy initiatives.

Pre-registration is required. To register, visit www.massmed.org/legislative-training. Questions? Contact Colleen Hennessey at chennessy@mms.org or (781) 434-7315. **VS**

UMass Medical Students Found "WooFood"



Photo courtesy of WorcesterScene.com

Three UMass Medical students have partnered with Worcester restaurant owners and chefs to incorporate healthy choices for patrons, promoting dishes with more vegetables, more whole grains, and less salt, sugar, and saturated fats. The WooFood program (named for the city of Worcester) is featured on January's MMS Physician Focus TV program, available online at www.physicianfocus.org.

Pictured: Adam Chin, Mitch Li, and Matt DeWolf, co-founders of WooFood, with Paul Barber (third from left), proprietor of the Flying Rhino cafe in Worcester.

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MASSACHUSETTS
MEDICAL SOCIETY

VITALSIGNS

VOLUME 18, ISSUE 2, FEBRUARY 2013

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MMS SPONSORED AND JOINTLY SPONSORED CME ACTIVITIES

LIVE CME ACTIVITIES

Go to www.massmed.org/cme/events or call (800) 843-6356. Unless otherwise noted, all events are held at MMS Headquarters, 860 Winter St., Waltham.

8th Annual Women's Cardiac Health Conference
Fri., Feb. 1, 8:00 a.m. to noon.

Preventing Falls in Older Patients: A Provider Tool Kit WEBINAR
Wed., Feb. 6, noon to 1:30 p.m., via live webinar.

The Impact of Effective Communication on Patients, Colleagues, and Metrics
Fri., Feb. 8, 8:00 am to noon.

How to Prepare for ACOs
Wed., Feb. 27, 6:30 to 9:00 p.m.

Managing Workplace Conflict
Thurs., March 7, 8:00 a.m. to 4:00 p.m. and Fri., March 8, 8:00 a.m. to 4:00 p.m.

Future Trends That Will Impact Radiologists and Their Practice
Wed., March 13, 7:30 to 9:30 p.m. Westin Hotel, Waltham

9th Annual Public Health Leadership Forum
Topic: Mental Health
Wed., April 3, 1:00 to 5:00 p.m.

Assessing Medication, Mental Health, and Cultural Needs during Sheltering
Tues., June 11, 6:00 to 9:00 p.m.

2nd Annual Addiction Medicine for All Providers Conference
Fri., June 21, and Sat., June 22, 8:00 a.m. to 5:00 p.m.

SAVE THE DATE
MMS Annual Education Program — Navigating the Currents of Change: Integrating Innovative Technologies into Your Clinical Practice
Fri., May 10

11th Annual Symposium on Men's Health
Wed., June 12

ONLINE CME ACTIVITIES

Go to www.massmed.org/cme.

Risk Management CME

End-of-Life Care

- The Importance of Discussing End-of-Life Care with Patients*
- 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

- Legal Advisor: Active Listening as a Tool for Improved Doctor-Patient Relationship
- Legal Advisor: Legal Duties and Options when a Patient Raises Suicide
- Bullies and Victims: Can You Tell the Difference?
- Seven Steps to Better Health Literacy
- Acid Suppression Therapy: Neutralizing the Hype
- Antitrust Considerations for Physicians in Massachusetts
- Dealing with Difficult Patients
- Dealing with the Changing Dynamic of Medical Staff
- The Changing Nature of Informed Consent: Informing Patients and Avoiding Litigation
- Incorporating Meaningful Use in the Specialty Practice

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

TO REGISTER FOR ANY OF THESE ACTIVITIES,
CALL (800) 843-6356.

CME CREDIT: These activities have been approved for
AMA PRA Category 1 Credit™.

For additional information, contact the Department of
Continuing Education and Certification at (800) 322-2303,
ext. 7306, or go to www.massmed.org/cmecenter.