Payment Reform in Massachusetts: The Next Chapter Diving Into Details

BY WILLIAM RYDER

Now that state’s payment reform law is in place and the dust has settled, it’s time to turn the Society’s attention to the nitty-gritty of rule-making and regulatory requirements.

The new legislation, also known as Chapter 224, created a whole body of new commissions and regulatory requirements to define the broad policy changes.

The MMS has been allocated representatives on some of those commissions. In others, our roles will vary, depending upon the Governor’s choice of participants.

The MMS is specifically included in a Health Care Workforce Advisory Council charged with improving access to health care through various programs designed to foster an adequate supply of health care providers. Workforce issues are a definitive MMS priority and area of expertise.

We are also on the Special Commission on Public Payer Reimbursement Rate, the Special Commission on Provider Price Variations, and the Special Commission on Graduate Medical Education. The first one will look at the impact of payment systems and rates on providers and insurers. The second will make recommendations to reduce variation, and the third is tasked with examining the economic, social, and educational value of graduate medical education and making recommendations for future funding.

There are several commissions without MMS statutorily required representation in which we hope to have major roles:

Engaging Patients in Their Own Health Care: Turning Rhetoric Into Reality

BY VICKI RITTERBAND

Rich Parker, M.D., has a simple way of helping patients stay on track with their weight loss. After they’ve discussed goals and strategies during an office visit, he’ll urge them to email their weight to him weekly. If they email “290,” he’ll reply back “285!!!”

“It gives them that extra motivation, knowing they have to send me the number each week and it’s no sweat off my brow,” said Dr. Parker, medical director of Beth Israel Deaconess Physician Organization. “Goal-setting with patients is a very helpful way to engage them. And when they’re ready to make changes, that’s when I pounce.”

As the health care system grapples with how to serve up higher quality care at lower prices, the patient’s role in maintaining and improving health is receiving a lot of attention. Traditionally, that role has translated as compliance (e.g., taking their medicine, losing those stubborn 50 pounds) with the onus on the patient. But increasingly, the idea of compliance has morphed into the notion of patient engagement, a pas de deux in which the physician is asked to play a leading role.

Pressure is coming from every direction. Federal incentives that help doctors afford electronic health records systems require that practices show how their technology plan better engages patients. Similarly, the notion of patient engagement figures prominently into health care reform’s two leading models: the patient-centered medical home and the accountable care organization. Even the Institute of Medicine has weighed in on the issue in its recent report, Best Care at Lower Cost: The Path to Continuous Improvement.

“Technology such as email is just one tool physicians are deploying today to better partner with patients. Other strategies include mastering more effective communication styles; leveraging the power of peer support; and increasing the transparency of patient health information. This is great news for addressing chronic and acute illness, but there’s a growing realization [that] we can only go so far with those tools. If the patients aren’t on board, their health will not improve.”

— Richard Lopez, M.D.

Motivational Interviewing Changing the “doctor knows best” paradigm is an important piece of the patient engagement puzzle, according to several practices. One communication strategy attempting to do that is motivational interviewing. First developed in the 1980s to treat problem drinkers, it’s now used to help patients struggling with all sorts of health-related behavioral changes. The strategy puts them in the driver’s seat and focuses on their readiness to make changes, as well as their willingness to do so.

Atrius Health has taught about 100 nurse practitioners to use motivational interviewing to help patients better manage their chronic diseases. At the VA Boston Healthcare System (VA BHS), three-quarters of the primary care staff has received communication training that includes the technique.

“Instead of saying, ‘You’re obese, let’s make changes,’ you ask the person open-ended questions, like ‘What health issues are you most concerned about?’ or ‘What would you like to work on?’” said Jacqueline K. Spencer, M.D., M.P.H., director of primary and ambulatory care at VA BHS.

Once the patient’s priorities are determined, the caregiver breaks down the needed changes into smaller pieces — exercising a few days a week, for example — and explores the patient’s ability to effect the change. “Too often in a doctor-patient exchange you simply tell them they need to start exercising,” she said. “Motivational interviewing helps create self-management goals that are concrete and actionable.”

Peer Support Some practices are shaking up the traditional ways physicians and patients interact by adding the element of peer support to the equation.

At Harvard Vanguard Medical Associates, between 6 and 12 patients who see the same physician for a particular disease can take advantage of shared medical visits. Patients begin with a session with a nurse for needs such as immunizations or test ordering. Then they join the
Patient Engagement
continued from page 1

group for an interactive educational session about their disease, co-run by their physician and a facilitator. If a patient requires an exam by the physician, the pair will peel off from the group to a nearby exam room as the group discussion continues.

"Patients really enjoy it because they get 90 minutes with their doctor and a lot of education during the process," said Richard Lopez, M.D., chief medical officer of Atrius Health, the parent organization of Harvard Vanguard. "And when you get together a group of people who are coming together for a common purpose, hearing each other's ideas, you tend to be more motivated as an individual to be engaged and to make changes."

Arlington Family Practice's wellness groups use that same strategy of combining peer with professional support. Physicians refer patients who have tried unsuccessfully to lose weight to the groups, which are small and facilitated by a doctor and nutritionist. "We emphasize accountability, starting with financial accountability, by asking patients to pay all of their co-pays for the 15 sessions in advance," said Laura Zucker, M.D. "Money can be a very effective tool in motivating people." The 60 patients who have participated over the past several years have cumulatively lost 1,200 pounds, according to Dr. Zucker. Her practice is now studying the members' long-term outcomes, including sustained changes to their weight, HbA1c values, and blood pressure, and intends to add a diabetes group run on the same model.

Some of the wellness group members also participate in the practice’s weekly “Walk with the Doctor” excursion — an hour-long walk that serves double-duty as an opportunity to talk to patients about topics such as the latest nutritional news. “We’ve had everyone from the mom pushing a baby carriage to 80-year-olds," said Dr. Zucker, one of the walk’s leaders. “It sends a message to all of our patients — whether or not they participate — that even the doctors are going to walk, that we all need to take care of ourselves.”

Transparency of Health Information

Granting patients better access to their personal health information is one more way practices are working to forge tighter partnerships with patients. Patient portals give patients a consolidated view of information, including immunization records, medication lists, preventive care needs and test results, as well as the ability to securely email their providers.

“It’s a great way to get patients engaged and provide them with a sense of control,” said Dr. Lopez, who noted that about 25 percent of Atrius' nearly one million members have signed up for its patient portal, MyHealth Online. “It allows them to more easily interact with the health care team, seek help and address inaccuracies in their records. It’s been very helpful.”

For the past several years, Atrius Health has also urged its internal medicine practices to provide patients with after-visit summaries that include an overview of what was talked about and a list of the lab, imaging, and referral orders the patient has to follow up with. “Patients sometimes freeze up in the exam room. The doctor says all these things and they’re so tense they don’t retain the information,” said Dr. Lopez. “We feel these summaries are an important part of completing the visit and getting patients on board with compliance.”

If patient portals and after visit summaries pull back the curtain on the mysteries of patient medical records, OpenNotes removes the curtain altogether. A pilot project at three medical settings, including Beth Israel Deaconess Medical Center and its primary care practices, OpenNotes invites patients to read their physicians’ encounter notes via a secure website.

“It’s a way of helping patients better understand what their doctor is thinking, take more of an interest in their own health care, and in some cases ask additional questions — perhaps about things that went unaddressed," said Sigall Bell, M.D., an infectious disease specialist at Beth Israel Deaconess Medical Center and a co-investigator of the OpenNotes project. "Any practice can operationalize OpenNotes by simply printing out visit notes for the patient. It’s not about a technology; it’s about connecting with patients and activating them in their own care.”

The jury is still out about which techniques or strategies are most effective in engaging patients, but physicians have little choice but to continue searching for what works best: “The irony is that we have great tools in medicine for addressing chronic and acute illness, but there’s a growing realization [that] we can only go so far with those tools,” said Dr. Lopez. “If the patients aren’t on board, their health will not improve.” vs

VITAL SIGNS is the member publication of the Massachusetts Medical Society.
EDITOR: Erica Noonan
STAFF WRITERS: Deb Beaulieu, Vicki Ritterband
EDITORIAL STAFF: Charles Alagero, Office of General Counsel; Robyn Alie, Public Health; Lori DiChiara, Government Relations; Kerry Ann Hayon, Managed Care; Stephen Phelan, Membership; Cathy Salas, West Central Regional Office; Jessica Vautour, Physician Health Services

PRODUCTION AND DESIGN: Department of Premedia and Publishing Services; Department of Printing Services

PRESIDENT: Richard V. Aghababian, M.D.
EXECUTIVE VICE PRESIDENT: Corinne Brodierick
DIRECTOR OF COMMUNICATIONS: Frank Fortin

Vital Signs is published monthly, with combined issues for June/July/August and December/January, by the Massachusetts Medical Society, 860 Winter Street, Waltham, MA 02451-1411. Circulation: controlled to MMS members. Address changes to MMS Dept. of Membership Services. Editorial correspondence to MMS Dept. of Communications. Telephone: (781) 434-7110, toll-free outside Massachusetts: (800) 322-2303; fax: (781) 642-0976; email: vitalsigns@mms.org.

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Spotlight On Success

Meaningful EHR Implementation

Implementation of electronic health records (EHRs) is bringing a cultural change to daily medical practice operations. The National Center for Health Statistics estimates 71.2 percent of Massachusetts office-based physician practices used some kind of EHR in 2011.

For practices that haven’t adopted EHR technology yet, the time is now. EHRs are important for enhancing patient care delivery and collaborating in accountable care organizations (ACOs) or integrated care networks. In order to adopt EHRs effectively, practices should be aware of several points essential for success.

• Evaluate Information Use and Flow: EHR implementation can disrupt a well-functioning system. Before adopting a new system, a practice should evaluate its own existing care system and consider the following questions: What systems are already in place? How is information recorded and exchanged? Who needs what kinds of information? Where do they use it? Once equipped with those answers, practices should be prepared to take the next step.

• Find a Compatible EHR: Several key considerations must be made when choosing an EHR, including flexibility, user-friendliness, mobility, and transition support. Flexibility must account for customization of the system; mobility is necessary for sharing patient information throughout the care setting; and transition support ensures a smooth integration of the EHR into the practice’s workflow.

• Institute Team-Wide Acceptance: Most importantly, groups should ensure that the workplace dynamic is maintained throughout EHR implementation. Teamwork should not suffer at the hands of technological innovation. Therefore, it is paramount that the system sustains the work environment.

EHR use will benefit patients and practices alike. Streamlined data will allow for streamlined care. Not only can patient care be enhanced through EHRs, but practice-wide improvements in communication, productivity, and data utilization can occur as well. VS

— Leif Brierley

For assistance with EHR implementation or general practice issues, contact the Physician Practice Resource Center at (781) 434-7702 or pprc@mms.org.

Law and Ethics

Physician Non-Competition Agreements

As more physicians enter into employment — by a hospital, ACO, group practice, or otherwise — and more entities come into Massachusetts from out of state, it is worth emphasizing that, in Massachusetts, non-competition agreements are unenforceable against physicians after the termination of their employment.

Generally, a non-competition agreement (or a “covenant not to compete”) is a clause found in employment contracts, under which one party (usually the employer) promises not compete with the other (usually the employer) after the employment relationship ends. Specifically, a non-competition agreement could prohibit a physician from practicing medicine in the same geographic area as the employer, until a certain amount of time has passed.

Massachusetts law, however, strongly values the right of the patient to be seen by his or her physician of choice, and does not allow physicians to agree not to compete, because such an agreement would limit patient choice of physicians. For example, in 1998, an unpublished Superior Court opinion refused to enforce a contractual provision that would have prevented a physician from soliciting patients or suggesting the transfer of their medical records to the physician’s new practice. In addition, the imposition of financial penalties for competition have been held to be unenforceable, so that a requirement to repay a practice’s recruiting costs, or to return a retirement bonus, will not be enforced against a physician who competes with his or her previous employer.

If you have questions about an employment contract, it is always wise to consult an attorney versed in health care and employment law who can help you understand your obligations under the contract, and whether parts of the agreement may not be enforced. VS

— Liz Rover Bailey, 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.
Landmark Tobacco Victory Celebrates 20th Anniversary on Nov. 3

On November 3, 1992, the voters of the Commonwealth of Massachusetts approved a referendum that increased the tax on cigarettes by 25 cents per pack and raised the tax on smokeless products by 25 percent of the wholesale price.

The ballot question directed that a Health Protection Fund, separate from the state’s General Fund, be created, and that a portion of the revenue from this tax be allocated to this fund for a comprehensive tobacco control program, including education and smoking cessation programs.

The ballot question passed 56 percent to 44 percent, and in the fall of 1993, the Massachusetts DPH established the Massachusetts Tobacco Control Program.

The coalition that waged this successful campaign — the Massachusetts Coalition for a Healthy Future (MCHF) — was led by a steering committee whose original members were the American Cancer Society, Blue Cross Blue Shield, and the MMS. Since the passage of the groundbreaking law, Tobacco Free Mass (formerly the MCHF) continues to advocate for laws to reduce tobacco use.

Through its advocacy, Massachusetts became the first state in the nation to divest state pension fund holdings in tobacco stocks in 1997, and the sixth to make all workplaces smoke-free — including restaurants and bars — in 2004.

The coalition also led the successful drive to provide a comprehensive and affordable tobacco cessation benefit in the MassHealth program in 2006. The MMS continues to be an active member of the coalition, whose chair is former MMS President Alice Coombs, M.D.

—Stephen Sheshtakofsky
Executive Director
Tobacco Free Mass

Resources for Treating Children During a Disaster

During a disaster or public health emergency, children are often injured or affected. However, the physicians, nurses, other health professionals and volunteers responding to the incident often have limited experience with pediatric patients and are thus unprepared to manage the specific physical, emotional, and developmental needs of children affected by a disaster.

The MMS Committee on Preparedness has created a directory of resources that can be readily accessed by physicians and other health care professionals needing information and training in pediatric disaster life support. These resources are designed to prepare multidisciplinary health care providers for general pediatric disaster care, including necessary equipment for pediatric patients in a disaster, triage assessment, stabilization, resuscitation, and the psychological effects of disaster on children.

The directory, which is located on the MMS website at www.massagefriends.org/preparedness, can be accessed as needed — prior to and during a disaster. It includes links to live and online CME programs as well as materials such as pocket guides and posters.

Anti-Tobacco Poster Contest Underway: Entries Due Feb. 15, 2013

The 18th Annual MMS and MMS Alliance Anti-Tobacco Poster Contest is underway. Contest kits are being mailed this month to pediatricians, family practitioners, and elementary and middle schools in Massachusetts.

The contest is designed to stress the dangers of tobacco use.

Children in grades one and two were asked to create a poster showing how “tobacco is bad for your body,” winners in grades three and four created posters showing “how tobacco affects other people,” and children in grades five and six created posters showing “why I won’t start smoking.”

The deadline for entries is February 15, 2013. Entries will be judged based on originality, artistic merit, and relevance to the theme. Contest winners will be honored at an awards ceremony at the Massachusetts State House. This past spring, the MMS and Alliance honored the 2012 Anti-Tobacco Poster Contest winners with an event hosted by Sen. Richard Moore (D-Uxbridge) and MMS President Richard V. Aghababian, M.D., with MMS Alliance President Gladys Chan and MMS Committee on Student Health and Sports Medicine Chair Alan Ashare, M.D., presenting the awards.

The 12 winning posters were chosen from more than 3,700 entries and became the basis for a 2013 calendar, which is included with the contest kits being mailed this month.

For more information about the contest, visit www.massmed.org/tobacco or call (800) 322-2303, ext. 7372.

Back row (left to right): MMS President Richard V. Aghababian, M.D., MMS Alliance President Gladys Chan, Anne Kane of East Walpole, Isabella Ames of Weymouth, Madison Evans of East Walpole, Abigail Golden of Weymouth, Elise Miller of Holliston, Claire Jungmann of Andover, Christine Ochola of Longmeadow, Alan Ashare, M.D., chair, MMS Committee on Student Health and Sports Medicine, Front row (left to right): Rachel Burke of East Walpole, Katherine Zeng of Reading, Cindy Siu of Malden, Caden Andrews of Weymouth, and Vincent Schmidt of Lawrence.
FEDERAL UPDATE

Congress Copes with SGR and Medicare Sequester

Soon we will know the outcome of the November 2012 presidential and congressional elections. Much is at stake, including the White House, control of the U.S. Senate, and ultimately the underlying philosophy defining the government’s responsibility to the individual.

Regardless of the outcome, the 112th Congress will return to Washington to face a long list of unfinished tasks.

For physicians and seniors, Congress once again needs to stop the impending 27 percent Medicare physician payment cut, also known as the Sustainable Growth Rate (SGR) formula, before January 1, 2013. An oft-repeated exercise which I sometimes refer to as “Sisyphian.” (For those rusty on their Greek mythology, Sisyphus is forced to roll a boulder up a steep hill, which tumbles back down when he reaches the top. Then the whole process starts again, lasting all eternity.)

This year’s SGR task is even more formidable, as Congress must deal with an additional 2 percent cut in Medicare spending mandated early next year by the Budget Control Act of 2011. This Medicare sequester could have dire consequences.

The AMA and other health provider groups have released a new report stating that up to 766,000 health care and related jobs could be lost by 2021 as a result of the predicted cuts. More than 17,000 of those job losses could occur in Massachusetts.

The MMS and more than 100 other state and specialty medical societies joined the AMA last month in calling for federal legislation nullifying the 2 percent cut in payments for physicians who treat Medicare patients, scheduled to take effect on New Year’s Day.

We plan to continue our advocacy throughout the fall, and will keep Vital Signs readers posted on any developments.

— VS

Ballot Question Materials Mailed to MMS Members in Massachusetts

Informational materials on this year’s state November 6 ballot questions on health care were mailed last month to all MMS members with a Massachusetts address.

The MMS is opposed to both ballot questions. Question 2 would authorize physician-assisted suicide. Question 3 would allow patients to use marijuana for medical purposes, following certification by a physician.

The materials include a one-page brochure on each ballot question outlining the reasons for the MMS’ opposition and eight-page white papers outlining the key arguments for each proposal.

“These are important health care questions for the state’s patients,” said MMS President Richard V. Aghababian, M.D., “and patients should know what we think and where we stand on these issues.”

All materials are in PDF format and can be downloaded for free at www.massmed.org/ballotquestions.

The MMS has also been active in recent months in initial regulatory hearings with the Division of Insurance (DOI) to spell out key definitions and provisions of Chapter 224 in regulations. Crucial discussions have revolved around definitions and requirements for registration of risk-bearing provider organizations and how the DOI will implement new local statutes that require parity in coverage of mental health and substance abuse.

While the headlines cover political races, it’s also a busy fall season in state government. The MMS’s leadership is actively involved in constant discussions and meetings with members of the Executive branch on how to effectively implement what the Legislature created in July.

Payment Reform continued from page 1

• A new task force, under the DPH, to review defensive medicine and overutilization
• A special task force charged with reviewing the accuracy of medical diagnoses
• The Massachusetts Psychiatric Society is formally included on a 19-person task force on behavioral health and substance abuse.
• A 20-member Commission on Prevention and Wellness at the DPH

The Massachusetts Medical Society has a bona fide physician-patient relationship for understandings that fall beyond the scope of the End of Life. This proposed law would allow a physician to a 60-day supply of marijuana.

On November 6, 2012, Massachusetts voters will be asked to approve or disapprove Question 2, a law proposed by initiative petition, “Prescribing Medication to a terminally ill patient’s request, to end that patient’s life.”

On November 6, 2012, Massachusetts voters will be asked to approve or disapprove Question 3, a law proposed by initiative petition, “Medical Use of Marijuana.” This proposed law would allow a patient diagnosed with a debilitating medical condition, such as cancer, glaucoma, AIDS, hepatitis C, ALS, or MS, to obtain a prescription for a 60-day supply of marijuana.

The Massachusetts Medical Society and more than 100 member societies joined the AMA last month in calling for federal legislation nullifying the 2 percent cut in payments for physicians who treat Medicare patients, scheduled to take effect on New Year’s Day.

We plan to continue our advocacy throughout the fall, and will keep Vital Signs readers posted on any developments.

— VS

LINKEDIN

Link In with MMS

Connect with your peers by joining our members-only LinkedIn group at www.massmed.org/linkedin.
Unprofessional behavior can happen at any time, anywhere, and frequently involves an individual at a high level of professional stature and authority. Often, it is a physician who behaves in an unprofessional manner toward someone of lesser authority. It most often happens when providers are stressed or tired, and such an incident can jeopardize patient safety.

Most physicians would even admit that, at some point in their professional practice life, they’ve had a meltdown. But some physicians engage in recurring behavior that must be addressed before harm comes to a patient, a staff member, or the reputation of the provider, group, or institution.

From a legal standpoint, we have obligations in respect to aberrant behavior. In Massachusetts, all health care providers (including doctors, nurses, psychologists, and others defined in Massachusetts General Laws [G.L.] Chapter 111, section 1) must report to the Board of Registration in Medicine (BRM) whenever there is a reasonable basis to believe that a physician is in violation of any of the laws, rules, or regulations of the BRM. The DPH also expects to be informed about incidents that involve the potential for patient harm. At the core of the matter is the simple fact that patient safety comes first. But we must also understand that the provider deserves due process and perhaps a chance to remediate his or her behavior.

Beyond the legal requirements, however, lies the ethical responsibility that we owe to one another. In our society, we have been accorded enormous privilege to review what we and our colleagues do, and have it protected from oversight by others. This is the essence of peer review and it’s not just applicable to clinical outcome — it applies to our professional behavior as licensed physicians as well. We do indeed have not only a legal imperative, but also a moral and ethical responsibility to be our colleague’s keeper.

This continuum of intervention can range from an impromptu, one-on-one hallway discussion to a documented conversation. As physicians, we should not overlook one of the most obvious causes for a colleague’s poor conduct, his or her own medical concerns. No matter what the reason is, however, if the behavior isn’t controlled, someone in the workplace may take it upon themselves to report to the institution or a regulatory agency. If a staff member alleges a “hostile environment” or if the BRM is contacted, a valuable opportunity to provide an early intervention for a colleague may be lost.

When the physician finally understands consequences of his or her continued unprofessional behavior, there should be confidential documentation of this understanding so that repeat instances can be quickly and appropriately addressed.

As physicians, we owe it to our colleagues, as well as our groups, clinics, and hospitals, to encourage everyone to practice medicine with requisite skill, safety, and appropriate workplace interactions.

Physician Health Services (PHS) is available for consultation, should you be considering how to address a colleague for whom you have concern. PHS is also available for support and assessment of the physician. For more information, please visit www.physicianhealth.org or call (781) 434-7404.

— James D. Butterick, M.D., and John A. Fromson, M.D.
The purpose of a medicinal garden is to tell the story of plants’ involvement in the healing practices of many civilizations, through the use of horticulture. The garden includes plants of proven scientific value and current therapeutic importance, as well as some that have medicinal value but became obsolete over time. A few have been proven to have no value, but are still grown because of their place in medical history, even if they no longer have a rightful place in the medicine cabinet.

In 1998, an ad hoc committee for landscape design was formed to collaborate with the building and landscape architects in designing gardens for the construction of the new Massachusetts Medical Society headquarters.

The building’s architect had two design themes: nature and medical history and tradition. The committee adopted the mindset of designing gardens for the campus rather than foundation plantings for the building, which produced gratifying results.

The late Shirley MacIver, M.D., MMS member and master gardener, proposed, designed, and created our medicinal garden.

In naming it Hortus Medicus, we joined a historical tradition dating back to medieval times, when the university system was first created in Europe. At that time, all European universities with medical schools had a medicinal garden, and all the medicinal gardens were called Hortus Medicus, because the language of instruction throughout all of Europe was Latin.

The purpose of a medicinal garden is to tell the story of plants’ involvement in the healing practices of many civilizations, through the use of horticulture. The garden includes plants of proven scientific value and current therapeutic importance, as well as some that have medicinal value but became obsolete over time. A few have been proven to have no value, but are still grown because of their place in medical history, even if they no longer have a rightful place in the medicine cabinet.

Dr. MacIver’s original design had 32 different varieties of medicinal plants (28 of which are still in cultivation). Over the past 14 years, the garden has grown in size, variety, and number of plants.

At present, at least 90 varieties of plants are in cultivation during any one growing season, with specimens spanning about six millennia of recorded medical history. The opium poppy (Papaver somniferum) — the source of the natural opiates — grows in our garden, and is the first plant to have its medicinal properties described and recorded in writing (encrypted on clay tablets).

We grow the Madagascar periwinkle (Catharanthus roseus), the source of some medications for chemotherapy of the acute leukemias and lymphomas of childhood and other malignancies. We also grow the May apple (Podophyllum peltatum), which is the source of medication for the chemotherapy of testicular carcinomas and other malignancies.

Of all the gardens on our campus, the Hortus Medicus is the most admired. It stands as the signature, a tribute to the healing and teaching missions of the Massachusetts Medical Society.

— George Santos, M.D.

The members of the AH&H&C MIN Executive Council would like to extend our gratitude to Dr. Santos and his wife, Dorothea, for their stewardship of this medicinal garden over the past 13 years. George and Dorothea have demonstrated their dedication and passion in taking care of this unique garden and offering all of us a place to step away for a moment from the issues of the day to admire the greenery and the colors.

ACROSS THE COMMONWEALTH

District News and Events

**Berkshire — Fall Meeting.** Mon., Nov. 19, 6:00 p.m. Location: Mazzeo’s, Pittsfield. Speaker: Jeffrey M. Drazen, M.D., editor-in-chief, NEJM. Topic: Two-Hundred Years of Medical Advances. For more information, contact Central Regional Office.

**Charles River — Delegates Meeting.** Tues., Nov. 27, 6:00 p.m. Location: MMS headquarters, Waltham. Delegates will meet to review the resolutions for the House of Delegates, Interim Meeting. For more information, contact Northeast Regional Office.

**Essex South/Essex North — Delegates Meeting.** Wed., Nov. 28, 6:00 p.m. Location: Beverly Depot, Beverly. For more information, contact Northeast Regional Office.

**Hampden — Fall Meeting.** Tues., Nov. 27, registration 5:30 p.m. and Delegates Meeting 6:30 p.m. Topic: When Bad Things Happen to Good Doctors. Speaker: Anthony Whitemore, M.D. Location: HDMS West Springfield. Delegates will meet to review the resolutions for House of Delegates, Interim Meeting. For more information, contact HDMS Office 413-736-0661 or hdmsoff@massmed.org.

**Middlesex Central — 5th Tuesday Program.** Tues., Oct. 30, 11:45 a.m. Location: Emerson Hospital, Concord. Guest Speaker: MMS President Richard V. Aghababian, M.D. For more information, contact Northeast Regional Office.

**Middlesex West — Delegates Meeting.** Wed., Nov. 28, 6:00 p.m. Location: MacPherson Hall, Framingham Union Hospital. Delegates will meet to review the resolutions for the House of Delegates, Interim Meeting. For more information, contact Northeast Regional Office.

**Norfolk — Delegates Meeting.** Thurs., Nov. 15, 6:00 p.m. Location: MMS headquarters, Waltham. Delegates will meet to review the resolutions for the House of Delegates, Interim Meeting. For more information, contact Northeast Regional Office.

**Norfolk South — Annual Toys for Tots Drive.** Tues., Dec. 4, 6:00 p.m. reception followed by dinner and entertainment. Location: Granite Links Golf Club, Quincy. For more information, contact Southeast Regional Office.

**Southeast — Regional Caucus.** Tues., Nov. 20, 6:00 p.m. Location: Lebaron Hills Country Club, Lakeville. Delegates from the Barnstable, Bristol North, Bristol South, Norfolk South, and Plymouth District Medical Societies will meet to review and discuss the resolutions prior to the 2012 Interim House of Delegates Meeting. For more information, contact Southeast Regional Office.

**Suffolk — Delegates Meeting.** Thurs., Nov. 15, 6:00 p.m. Location: East Garden Room, Massachusetts General Hospital. Delegates will meet to review the resolutions for the House of Delegates Interim Meeting. For more information, contact Northeast Regional Office.

**Worcester — Fall Meeting.** Wed., Nov. 14, 5:30 p.m. Location: Beechwood Hotel, Worcester. The dinner meeting includes the A. Jane Fitzpatrick Community Service Award, the WDMS Career Achievement Award, and scholarship award presentations. For more information, contact Joyce Carigilia (508) 753-1579.

If you have news for Across the Commonwealth, contact Michele Jussaume, Northeast Regional Office, at (800) 944-5562 or mjjusaume@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 SPONSORED AND JOINTLY SPONSORED CME ACTIVITIES

LIVE CME ACTIVITIES
Go to www.massmed.org/cme/events or call (800) 843-6356. Unless otherwise noted, event location is MMS headquarters, 860 Winter St., Waltham, MA.

Directors of Medical Education Conference
Thurs., Nov. 8, 8:00 a.m. to 3:00 p.m.

MSCO 2012 Annual Meeting: Burkitt’s Lymphoma: From Uganda to the U.S. — a Personal Journey
Thurs., Nov. 8, 5:30 p.m. to 8:30 p.m., Hilton Boston/Dedham, Dedham, MA

Webinar — Physician Contracting Basics
Fri., Nov. 16, noon to 1:00 p.m.

SAVE THE DATE
8th Annual Women’s Cardiac Health Conference
Fri., Feb. 1, 2013

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*

• 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
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• Incorporating Meaningful Use in the Specialty Practice
• Legal Advisor: Legal Duties and Options when a Patient Raises Suicide
• Incorporating Meaningful Use in the Specialty Practice
• Antitrust Considerations for Physicians in Massachusetts
• 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: Informing Patients and Avoiding Litigation

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

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