Disclosure, Apology and Offer: A New Approach to Medical Liability

BY DEBRA BEAULIEU

A lthough juries find in favor of physicians in the vast majority of malpractice cases that make it to court, the often-years-long battle in our current litigation system leaves physicians far from unscathed.

Massachusetts is poised to make changes that will better promote healing for all parties involved — and prevent recurrence of mistakes — by adopting a policy of Disclosure, Apology and Offer (DA&O) when patients suffer avoidable medical harms.

There are a number of reasons proponents see DA&O as good for physicians as it is for patients.

“This is a fundamental transformation of liability systems from one that is reactive and very adversarial and creates a culture of secrecy and a blame-and-denial mentality,” says Alan Woodward, M.D., past president of the MMS and chair of its Committee on Professional Liability.

“What we’re transforming to is exactly the opposite. It’s a very proactive system where physicians can advocate for patients who are injured rather than being told they can’t even talk to them,” said Dr. Woodward.

The effort was launched this April by an alliance of health organizations, including the Massachusetts Medical Society, with the Commonwealth’s Roadmap to Reform, which was the result of a 2010 planning grant from the Agency for Healthcare Research and Quality made to the Massachusetts Medical Society, with organizations, including the Massachusetts Medical Society, with organizations, including the Massachusetts Medical Society.

MMS and Beth Israel Deaconess Medical Center (BIDMC) as part of President Obama’s Patient Safety and Medical Liability Initiative.

Using the grant, seven Massachusetts hospitals, including Beth Israel Deaconess Medical Center in Boston, Beth Israel Deaconess Hospital-Needham, Beth Israel Deaconess Hospital-Milton, Baystate Medical Center in Springfield, Baystate Franklin Medical Center in Greenfield, Baystate Mary Lane Hospital in Ware, and Massachusetts General Hospital, will pilot test a DA&O approach modeled after the system used by the University of Michigan.

How DA&O Works

Under this model, when unanticipated adverse outcomes occur, patients and their families are provided full disclosure of what happened, what it means for the patient medically, and what will be done to prevent the error from reoccurring.

Physicians and health care organizations are given the opportunity to apologize without fear of their words being later used against them in court. Organizations work with their liability insurers to give patients a fair and timely offer of financial compensation.

By giving patients the opportunity to receive transparent information and prompt financial recourse, the hope is that the court system would be used only as a last resort.

The ability to address adverse outcomes quickly is another major advantage of DA&O, Dr. Woodward added, considering that patients who bring medical malpractice lawsuits in Massachusetts wait an average of five-and-a-half years until receiving an award.

Society Adopts Medical Marijuana Resolution; Considers the Future of Physician Groups

BY ERICA NOONAN

With a state ballot question on medical marijuana looming in the near future, the House of Delegates voted to oppose the legalization of medicinal marijuana in the absence of scientific studies that demonstrate its safety and efficacy.

The vote, which passed by a two-thirds margin, came after lengthy debate during the Society’s 2012 Annual Meeting on May 19 in Boston.

Many members felt that because Massachusetts voters would be grappling with the issue in November, it was important for the Society to weigh in.

The Society has a longstanding policy opposing smoking marijuana for recreational purposes, but also recognizing the need for clinical trials to study marijuana for medical use.

The multi-part marijuana resolution passed by the HOD last month also recommended that the U.S. Drug Enforcement Administration reclassify marijuana so its potential medicinal use can be further studied and possibly regulated.

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Medical Liability
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Perhaps the most promising aspect of D&O, however, is that the system promotes improved patient safety, said Evan Benjamin, M.D., senior vice president and chief quality officer for Baystate Health and associate professor of medicine at Tufts University School of Medicine. Although health care organizations have long performed root-cause analyses to determine the reasons medical mistakes occur, a prevailing culture of secrecy has undermined their ability to use that information optimally. “The current malpractice system, which encourages people to hide errors and encourages people to sue, really has the exact opposite effect of what we’re trying to achieve in the patient safety movement,” said Dr. Benjamin. “We’re trying to improve the transparency of events when there is an error so we can learn from it. D&O offers an approach that is respecting the patient in allowing them to have redress for failure, but also complements the patient safety movement as we’re trying to continue to learn,” he said.

Education and Support
Despite all of its potential benefits, implementing D&O involves a learning curve, noted Dr. Benjamin, who has been using a policy of disclosure and apology throughout Baystate Health for the past four years. “It’s been a long journey for us in terms of investing in patient safety,” he said, “but we’ve seen improvements in our relations with patients and the support we’ve been able to offer patients.” Organizations must first foster a cultural change in which physicians understand the value of transparency and become comfortable discussing matters they’ve traditionally been urged to hold close to the chest, Dr. Benjamin said. Once physicians adapt to the new mentality, they need training and support to learn how to conduct such difficult conversations with patients and their families.

To help facilitate change, Baystate gave its physicians access to a team of coaches available to work through how to start the conversation once an incident occurred — a resource Dr. Woodward said was essential. “We know that beyond just providing education, you need support at the moment of the incident,” Dr. Woodward said. “You need to have peer mentors who can help, maybe the chief medical officer at the institution or others who can work with the physician in explaining this type of situation when communication is often very difficult.”

Addressing Misconceptions
Dr. Woodward said he intends to speak to medical organizations across the state about the new approach to adverse events and how to implement it. One key point of this message, according to Kenneth Sands, M.D., senior vice president for medical liability at BIDMC, is that D&O does not constitute no-fault insurance in which patients who are injured would be indemnified regardless of fault. Rather, compensation would generally only be offered when a root-cause analysis clearly demonstrates that the health provider or system is at fault for a preventable event, such as a wrong-site surgery or other unforeseen consequence.

Dr. Benjamin concurred that the question of which incidents fit the protocol is tricky. “We don’t really have all the answers, because every case is different and the communication is different in every case, but that’s a common question that comes up,” he said. “The way we’ve approached this is really dealing with the truly obvious cases where there was an unexpected adverse event that we also believed was preventable.”

And while D&O does have some barriers to overcome, the allegation that it could manipulate patients or put them in a position to assess offers without fully understanding their rights is unfounded, Dr. Woodward said, noting that patients are told to obtain independent counsel while going through the D&O process.

“The last thing you want is to have made an offer to a patient and have them accept it and then feel as though they were pushed into it or didn’t have good counsel,” he says. “All of this is trying... continued on next page
Are Claims Problems Plaguing You?

MMS Regional Offices to Host Individual Claims Consultation Days

Annual Individual Claims Consultation (ICC) days will be taking place during the months of July, August, and September. These days are designed to allow MMS member physicians and their practices to schedule 30-minute trouble-shooting sessions with health plans (listed in the table below) in order to focus on adjudication of troublesome claims.

Representatives from the health plans will be on hand to review claims with physicians and their office staff in order to facilitate claims processing. To schedule an appointment for one of the upcoming sessions, please contact the appropriate regional office at the number indicated below.

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<td>7/19/12 9 a.m. to 4 p.m. (800) 322-3301</td>
<td>8/16/12 9 a.m. to 4 p.m. (800) 944-5562</td>
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Note: ✓ denotes plans that will be in attendance.

LAW AND ETHICS

Reporting Patients to the Registry of Motor Vehicles

The Massachusetts Registry of Motor Vehicles (RMV) accepts voluntary reports from health care providers regarding patients with conditions that may affect their ability to safely operate a motor vehicle.

However, until recently, there were no legal protections against claims of breach of confidentiality or violation of Massachusetts privacy law. In late 2010, An Act Relative to Safe Driving went into effect, giving health care providers immunity from civil liability when reporting patients to the RMV.

Under this law, if a health care provider acting in his or her professional capacity has reasonable cause to believe that a patient is not physically or medically capable of safely operating a motor vehicle — or has a cognitive or functional impairment that will affect that patient’s ability to safely operate a motor vehicle — the health care provider may make a report to the RMV requesting medical evaluation of the patient’s ability to safely operate a motor vehicle.

This report must be based on observations or evidence of the effect of that condition or impairment on the patient’s ability to safely operate a motor vehicle and not solely on the patient’s age or on the diagnosis of a medical condition or cognitive or functional impairment. This law also protects health care providers who choose not to report a patient to the RMV from civil liability that might otherwise result from not making the report.

As part of the 2010 law, the Department of Public Health (DPH), in consultation with the RMV’s Medical Advisory Board, was required to promulgate regulations designating cognitive and functional impairments that are likely to affect a person’s ability to safely operate a motor vehicle.

In early May 2012, the DPH’s Public Health Council approved these regulations, which define functional and cognitive impairments and identify impairments relevant to driving (those that limit a person’s ability to sustain attention, refrain from impulsive responding, maintain a firm grasp on or manipulate a steering wheel, etc.).

While this new law makes it clear that the Massachusetts Legislature wants to encourage good-faith reporting by physicians, the court has yet to address how HIPAA and other federal laws might impact a physician who files a report under these state laws. [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.

Medical Liability continued

to provide an option to patients that is much better, much more efficient, much more equitable, and is not in any way an attempt to ‘chintz’ the patient.”

The University of Michigan model, in fact, promotes compensating patients generously, he added. Cost savings come from not having to hire lawyers and experts to spend years fighting out cases that could be resolved in months.

Overcoming Barriers

The MMS and BIDMC have created the Roadmap for Removing Barriers to DA&O in Massachusetts, which cites a number of potential impediments to the program’s success. While many of these, such as physician discomfort with disclosure, can be managed through educational efforts, more substantive changes will be needed to ensure physician name-based reporting of safety events and insurer settlements doesn’t unfairly penalize physicians.

Part of the payment reform legislation released in May proposes changes to reporting requirements that would prevent giving individual physicians a black mark when their insurers make payments for systems-based errors. For example, if a patient were harmed from a blood transfusion because the blood was mismatched in the lab, as long as it was an appropriate transfusion, that mistake would not be reported against the individual doctor, Woodward explains.

While it remains to be seen which proposals will ultimately become law, the pilot program, along with a statewide push toward DA&O, will place Massachusetts squarely at the forefront of liability reform.

“This is precedent-setting nationally,” Dr. Woodward said, “We sat down with these parties, and we are going to put patients first and patient safety first and provide a legal framework that encourages everyone to do the right thing in improving patient safety instead of thwarting patient safety, which is what the current system does.” [VS]

WWW.MASSMED.ORG
Preventing Heat Illness During Exercise

With summer here, it’s important to ensure adequate hydration during exercise to reduce the risk of heat exhaustion, heat cramps, or heat stroke, which can be fatal.

As body temperature rises during exercise, evaporation of sweat is the primary mechanism used to maintain thermoregulation. This response can be blunted in hot and humid conditions when sweat evaporation is less effective. Children are at greater risk because they have lower sweating rates than adults.

Dehydration can lead to heat stroke, which requires immediate cooling — preferably in an ice bath — and emergency medical evaluation. Overhydration can be just as dangerous and lead to symptomatic exercise-associated hyponatremia, which can be life threatening. Symptoms of hyponatremia include confusion, post-exercise weight gain, nausea, vomiting, and muscle cramps.

Environmental conditions, clothing, duration and intensity of exercise, age, fitness level, body composition, and sweating rates all contribute to variable water and electrolyte losses during physical activity. Excessive fluid loss greater than 2% body-weight loss should be prevented.

What to drink during physical activity depends on the duration, intensity, and environmental conditions. The goal is to begin activity in a euhydrated state, which can be indicated by clear or light colored urine. Prehydration should begin several hours before exercise to allow for fluid absorption and return of normal urine output. Consuming beverages with sodium or small portions of salty foods can stimulate thirst and help retain fluids consumed.

Water is generally adequate for physical activity lasting less than an hour and should be consumed periodically during exercise. During longer activities, fluid replacement beverages with the following carbohydrate and electrolyte concentrations are recommended: 6 to 8% carbohydrate, 20 to 30 mEq L\(^{-1}\) sodium and 2 to 5 mEq L\(^{-1}\) potassium. Greater than 8% carbohydrates can cause GI upset.

Post-exercise, euhydration is often restored with regular meals and drinks. Individuals with significant dehydration should drink about 1.5 liters of fluid for each kilogram of body weight lost.

During exercise, carbonated beverages and fruit juices can cause GI upset and should be avoided, as should energy drinks that contain stimulants (e.g., herbs or caffeine) and high carbohydrate concentrations. Stimulants may impair athletic performance or cause dangerous health issues such as arrhythmia.

— Katherine Riggert, D.O., MMS Committee on Student Health and Sports Medicine

MMS Foundation Awards Grants to 14 Massachusetts Programs

This spring, the Massachusetts Medical Society and Alliance Charitable Foundation awarded $182,500 in grants to 14 Massachusetts programs promoting the health and welfare of medically underserved people in Massachusetts.

Half of the 14 programs that were awarded grants have not previously received funding from the Foundation. These programs include those that follow.

Whittier Street Health Center in Roxbury was awarded a $30,000 grant to support the implementation of its Centering Parenting program, which teaches parents how to assess and care for their baby’s health and their own, and develop a support network for the baby’s first year of life.

Harvard Street Neighborhood Health Center in Dorchester received $25,000 to support a half-time pediatric care coordinator to facilitate medical coordination, provide family education, and assist with housing, school, and financial needs.

MAP for Health in Boston was awarded $20,000 to support the establishment of a community health access network to increase screening for and detection of hepatitis B in the Asian and Pacific Islander community.

Sociedad Latina in Roxbury received $10,000 to support the expansion of mental health services for Latino youth and families in the community through enhanced case management and weekly mental health workshops for families.

Cuttyhunk Medical Services was awarded a $5,000 grant to advance an island-wide health project designed to mitigate Lyme disease and Ehrlichiosis. Some of the funding will also be used to improve the agency’s medical equipment.

The following programs, which have received funding from the Foundation in previous years, also were awarded grants: the Metro West Free Medical Program, Peer Health Exchange, Volunteers in Medicine Berkshires, REACH Beyond Domestic Violence, Holyoke Health Center, Father Bill’s and MainSpring, Boys and Girls Clubs of Metro West, and the Sharewood Project.

Previously, the Foundation awarded $25,000 to the Albert Schweitzer Fellowship Program, and $2,000 each to four recipients of its International Fellowship Program, and $25,000 to the Albert Schweitzer Fellowship Program, and $2,000 each to four recipients of its International Fellowship Program, and $25,000 to the Albert Schweitzer Fellowship Program, and $2,000 each to four recipients of its International Fellowship Program, and $25,000 to the Albert Schweitzer Fellowship Program, and $2,000 each to four recipients of its International Fellowship Program, and $25,000 to the Albert Schweitzer Fellowship Program, and $2,000 each to four recipients of its International Fellowship Program. 

Previously, the Foundation awarded $25,000 to the Albert Schweitzer Fellowship Program, and $2,000 each to four recipients of its International Health Studies grants, bringing its total 2011–2012 grants to $215,500. Since its inception in 2000, the Foundation has awarded more than $2.3 million in grants.

— Robyn Alie

2012 HARBOR WALK

MMS members gathered at the Seaport Hotel before the 2012 Harbor Walk during the Annual Meeting.
Payment Reform Advances; Conference Committee Deadline Is July 31

Earlier this month, the Massachusetts House of Representatives completed deliberations on its 278-page health care payment reform bill, voting 148 to 7 to pass H.4127, An Act Relative to Health Care Quality Improvement and Cost Reduction.

The bill limits health care spending to specific benchmarks through 2027 and creates a new Division of Health Care Cost and Quality, under the executive branch of state government, to oversee compliance.

It also imposes a “luxury tax” on providers whose costs exceed 20 percent of the comparable state median. There are numerous new requirements on physicians, hospitals, and insurers to publicly report cost and quality information and patient cost-sharing.

Like the Senate’s payment reform bill, H.4127 includes the Michigan model of disclosure, apology and offer and establishes a 182-day “cooling off” period upon the filing of a notice of a claim.

The House requires any physician group with 25 or more physicians to be certified by the Department of Public Health. The House gives the attorney general the right to block unreasonable increases in rates and block changes that adversely affect patient access and quality of care. In the Senate bill, groups that exceed the benchmark must file improvement plans.

Cost Containment
• The House’s benchmark is 3.6 percent for 2012 and 2013. In 2014 and 2015, it would be equal to the growth in the state’s economy (as measured by the gross state product, or GSP). From 2016 to 2026, it would be equal to a half percentage point below the GSP from 2016 to 2026, and equal to one point above the GSP after 2027.
• The Senate’s cost benchmark is a half point above the GSP through 2015 and equal to the GSP from 2016 to 2026.
• The House imposes a penalty on providers whose costs are 20 percent higher than the benchmark. The House gives the attorney general the right to block unreasonable increases in rates and block changes that adversely affect patient access and quality of care. In the Senate bill, groups that exceed the benchmark must file improvement plans.

Market Power
• The House subjects provider groups of 10 or more physicians to a market impact review.
• The Senate gives the attorney general the power to prevent excess consolidation and collusion.

Certification
• The House requires any physician group with 25 or more physicians to be certified by the Department of Public Health.
• The Senate requires certification for all providers entering into alternative contracts. It exempts groups with less than $500,000 in annual net patient service revenue and fewer than five affiliated physicians if the group does not accept risk.

Electronic Health Records
• The House requires providers to adopt EHRs that are fully interoperable and connect to the statewide health information exchange.
• The Senate updates the existing requirement for EHR proficiency by 2015 by requiring physicians to demonstrate the skills to comply with the federal government’s meaningful use requirements.

MMS Weighs in on Stage 2 Meaningful Use Rules

The MMS recently joined with the AMA and 99 other national medical specialty societies to comment on the proposed Stage 2 Meaningful Use regulations for electronic health records.

The comments recommended a robust evaluation of Stage 1, opposing high reporting measurement thresholds for physicians and encouraging the streamlining of requirements, including adequate exclusions and reporting on clinically relevant quality measures in at least two domains.

The MMS also submitted its own organizational comments to supplement those developed by the AMA. The Society urged the CMS to recognize the vastly different resources, capabilities, and capacities of physician practices to adopt these new technologies.

The MMS also outlined its concerns about penalties levied against some Massachusetts physicians who have been successfully e-prescribing for years, but were found to have used certain codes improperly.

The MMS is collecting data and actively working with the AMA to address problems with the federal e-prescribing program. If you have encountered problems or unexpected penalties, please send a short email to acalcagno@mms.org describing your experience, including “ERX” in the subject line of your email.

— Alex Calcagno

Make Your Voice Heard on Beacon Hill and Capitol Hill

The new MMS Legislative Action Center provides MMS members with online tools to:
• Respond to MMS Legislative Alerts
• Send messages to elected officials about key bills
• Browse state and national legislation
• Review the recent votes of legislation and members of Congress
• Find election information
• Find voter registration information

www.massmed.org/actioncenter

Ronna Wallace contributed to this report.
**PHYSICIAN HEALTH MATTERS**

When You Think a Colleague Needs Support

In our three-part Q&A series for Vital Signs, Physician Health Services, Inc. (PHS) discussed how to identify a colleague who may need referral for support for a health concern and how to consider reporting obligations.

Our final installment examines how to approach a colleague, especially when they are reluctant to accept help.

**Why are physicians reluctant to seek help?**

They often deny their symptoms, their schedules are too busy, or they are reluctant to share their history due to embarrassment or fear of exposure. They may be unable to recognize their symptoms, and the denial of a problem can lead them to become isolated and fearful of discovery. Even those closest to the physician might not recognize the problem.

**What happens when I contact PHS?**

PHS, a corporation of the Massachusetts Medical Society, provides assistance and support to all Massachusetts physicians, residents, and medical students. Anyone that comes to PHS is assured confidentiality when meeting with the PHS director or associate director. PHS will assess the circumstances while offering additional resources. Support groups offered by PHS are also confidential — attendees are not even known to PHS.

**Is there proof that PHS works?**

PHS outcomes are more successful than outcomes for the general public, suggesting an optimal chance of recovery for those physicians and medical students that seek help. PHS has a 75 percent success rate for both the substance use and the behavioral health monitoring contracts of the physicians and medical students who have been monitored.

**What if the physician or medical student declines a PHS referral?**

Even after learning about the benefits of PHS and how it can help, some individuals still won’t visit PHS. Consult with PHS even when the physician refuses. A review of the circumstances can help clarify the support PHS can provide, as well as allow for discussion of the implications of the physician choosing not to proceed, which can then be relayed back to the physician.

PHS can also review potential mandated reporting requirements with the referrer and the potential need for the physician to notify the BRM upon license renewal, which also can be shared with the physician.

**Who do I talk with at PHS?**

Call PHS at (781) 434-7404 to speak with Director Luis Sanchez, M.D., Linda Bresnahan, director of program operations, or Debra Grossbaum, Esq., PHS attorney. For more information, please visit our website at www.physicianhealth.org.

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**NEJM Documentary Film**

In celebration of 200 years of continuous publication, the New England Journal of Medicine (NEJM) announced the release of a documentary film, now available for viewing on the NEJM 200th Anniversary website.

Getting Better is a three-part, 45-minute documentary that explores the evolution of knowledge in medicine and some of the remarkable advances reported in NEJM, including the use of anesthesia in surgery, successful cancer therapies, and treatments for HIV/AIDS.

Watch it now at NEJM200.NEJM.org.

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**Medicaid EHR Incentive Funds Available — Learn How to Qualify**

If you qualify under the Medicaid EHR Incentive Program, you can apply for the initial $21,500 of a 6-year $64,750 incentive solely on the basis of a signed contract.

The Massachusetts Medicaid EHR Incentive Payment Program will hold regional meetings across the Commonwealth this summer. Participants will learn more about meaningful use and many other health information technology topics.

**Wednesday, August 8, 10:00 a.m. to 12:00 p.m.**
Jordan Hospital, Plymouth

**Tuesday, August 14, 10:00 a.m. to 12:30 p.m.**
Massachusetts League of Community Health Centers, Boston

For more information or to register for an event, contact the Massachusetts Medicaid EHR Incentive Payment Program at (855) 627-7347 or massehr@masstech.org.

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**LEGAL ADVISORY PLAN**

Member Benefit Spotlight: The Legal Advisory Plan

A patient filed a complaint against her PCP, alleging he refused to provide her with pain medication. The patient had demonstrated drug-seeking behavior with prior physicians, such as requesting refills of narcotic medications sooner than the prescription should have run out, and was beginning to do so with him.

When the physician declined to fill the prescription and attempted to review a plan to reduce the dosage, the patient became verbally abusive and threatening toward the physician and his staff, demanded the physician’s home phone number, and mentioned harming herself.

The physician sent the patient a termination letter and, subsequently, the patient filed a complaint with the Board of Registration in Medicine (BRM).

This was an actual situation a physician in Massachusetts brought to the lawyers of the Legal Advisory Plan. The complaint was later dismissed after the BRM’s review of the attorney-assisted written response.

Members of the LAP are automatically covered for assistance with responses to the BRM. For $70 a year, LAP members are also covered until the board initiates a formal “show cause” proceeding or suspends or refuses to renew your license, whichever comes first.

Without the Legal Advisory Plan, physicians can expect to pay up to $1,000 in fees to hire a lawyer to craft a response to the board. And in a vast majority of cases, such a response is all that’s needed to dismiss a complaint.

This plan is an exclusive MMS member benefit. To apply, call (800) 322-2303, ext. 7311, or email lap@massmed.org.
The following deaths of MMS members were reported to the Society in March, April, and May 2012. We also note member deaths on the MMS website at www.massmed.org/memoriam.


Robert A. Bolduc, M.D., 96; Shrewsbury, MA; Tufts University School of Medicine, 1939. Died November 16, 2009.

Gerald E. Bowen, M.D., 78; Shrewsbury, MA; Tufts University School of Medicine, 1958. Died May 6, 2011.


Frederick O. Buckley, M.D., 89; Tufts University School of Medicine, 1951. Died January 6, 2012.


George Cytroen, M.D., 88; Framingham, MA; Columbia University, 1947. Died February 5, 2012.

Philip J. Doherty, M.D., 74; Milton, MA; Georgetown School of Medicine, 1963. Died June 6, 2011.

Audrey Fitzpatrick, M.D., 92; Tufts University School of Medicine, 1942. Died May 3, 2009.

Sol Freedman, M.D., 89; Boston, MA; Middlesex University School of Medicine, 1945. Died February 7, 2011.

Joseph T. Giannmalvo, M.D., 93; Tufts University School of Medicine, 1945. Died March 30, 2012.


Joel M. Johnson Jr., M.D., 89; Tufts University School of Medicine, 1945. Died January 24, 2010.

Melvin H. Levin, M.D., 89; Chestnut Hill, MA; Tulane University School of Medicine, 1945. Died April 11, 2012.

Francis C. Mason, M.D., 85; Norwood, MA; Boston University School of Medicine, 1954. Died December 25, 2011.

John B. Petter, M.D., 92; Worcester, MA; University of Virginia School of Medicine, 1943. Died October 3, 2011.

Jason B. Roche, M.D., 90; Yarmouthport, MA; Creighton University School of Medicine, 1945. Died April 3, 2012.


Walter R. Schur, M.D., 96; Hollis, NH; Middlesex University School of Medicine, 1940. Died May 30, 2011.

Richard R. Smith, M.D., 78; Hingham, MA; Boston University School of Medicine, 1960. Died April 13, 2012.


MMS SPONSORED AND JOINTLY SPONSORED CME ACTIVITIES

LIVE CME ACTIVITIES
Go to www.massmed.org/cme/events. Unless otherwise noted, event location is MMS headquarters, Waltham.

Management of Carotid Artery Stenosis and Acute Stoke
Sat., Sept. 29, 7:45 a.m. to 3:45 p.m.

Adolescent Screening Brief Intervention and Referral to Treatment
Tues., Oct. 9, 8:30 a.m. to 4:30 p.m.

CME Accreditation Orientation
Tues., Oct. 16, 8:30 a.m. to 1:45 p.m.

Managing Workplace Conflict
Tues., Nov. 1, 8:00 a.m. to 4:00 p.m.
Fri., Nov. 2, 8:00 a.m. to 3:00 p.m.

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*

Public Health
• MA Responds Orientation Course
• Avoiding a Disaster during a Disaster

Other Risk Management CME
• Acid Suppression Therapy: Taking the Heartburn Out of the Evidence
• The Importance of Data Analytics in Physician Practice
• Seven Steps to Better Health Literacy*
• A Path to ACOs
• Dealing with Difficult Patients
• Dealing with the Changing Dynamic of Medical Staff
• The Changing Nature of Informed Consent: Informing Patients and Avoiding Litigation
• Avoiding Failure to Diagnose Suits
• Physician Practices Scramble to Comply with New Privacy Regulations

• Health Care Providers Brace for Medicare Audits*
• Social Networking 101 for Physicians
• Terminating the Doctor-Patient Relationship
• Informing Patients and Avoiding Litigation
• Boundary Issues in the Physician-Patient Relationship

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

Risk Management
massmed.org/cme

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CME

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