

VITAL SIGNS



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*Every physician matters,
each patient counts.*



MMS members hear testimony at the Annual Meeting on supervised injection facilities as a means of addressing the opioids crisis. See President's Message, page 2.

VOLUME 22, ISSUE 6, SUMMER 2017

Patients Are Feeling Crushed by Health Care Cost Sharing: How Can Physicians Be Part of the Solution?

BY LUCY BERRINGTON, M.S.
VITAL SIGNS EDITOR

Health care costs are shifting onto consumers, with disturbing implications for patients, physicians, and other stakeholders. Patients are increasingly likely to avoid care. They are less able to pay their medical bills. As individuals and families grapple with rising cost sharing, their experience is raising challenging questions in medical, legislative, and regulatory circles. To what extent should patient costs drive decisions about care? Is it physicians' responsibility to consider patients' financial burden? How can physicians effectively partner with patients on this issue, as they do on other aspects of care?

The Medical Society is approaching this from several angles, including legislative advocacy, an informational report on high deductibles and other cost-sharing mechanisms, and evolving support and services for medical practices. At the state

level, legislators — long used to wrestling with health care costs as a share of the state budget — are increasingly confronted with the impact on constituents' wallets. "In the State House it has become harder to ignore the effects of health care costs on families and individuals. We're seeing a push toward value-based insurance design and efforts to increase transparency on costs," says Brendan Abel, legislative counsel for the MMS. At the local level, MMS specialists are seeing tensions between patients and providers. "When a practice attempts to collect, they often encounter frustrated patients who thought their insurer covered the cost," says Jillian Pedrotty of the Physician Practice Resource Center.

The Implications of Higher Cost Sharing

To keep premiums at a reasonable price for employers and individuals, insurers are increasingly using tools like higher deductibles, co-insurance, and tiered co-payments.

High deductibles are particularly burdensome for vulnerable populations, including low-wage workers and people with chronic conditions, studies show.

For physicians, the issue is about both their ethical responsibility toward patients and, increasingly, their own livelihood. High-deductible plans can create a double pain point for providers. They often deter patients from accessing needed care, and they require providers to collect a greater share of their fee directly from patients, a dynamic that is driving up bad debt for physicians and health care systems. "Doctors in hospitals providing care to underserved populations are getting hurt badly," says Ron Dunlap, M.D., a cardiologist at South Shore Hospital and a past president of the MMS. "Lower-income patients are not coming in for screenings, which can lead to both worse outcomes and lower quality scores for physicians, resulting in lower reimbursements."

A report by the MMS on the effects of high-deductible health plans on patient health and the financial impact on medical practices will be published this summer. The goal of the report is to help the Medical Society devise advocacy relating to relevant patient education and policies, health care delivery systems, cost transparency, and payment



Illustration by Chris Twichell

models that improve the ability to collect payments from patients and promote patients' access to necessary medical care.

The Role of Physician Referrals

In the context of rising cost sharing, some of the health care decisions taken by patients seem counterintuitive. Why, for example, are they going to academic medical centers for treatment that could be provided at equivalent quality and lower cost in their own communities? This phenomenon is especially pronounced in Massachusetts, according to the Health Policy Commission (HPC). A 2016 study by the HPC and Tufts University School of Medicine (TUSM)

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Massachusetts Medical Society Elects Officers for 2017–2018
Henry L. Dorkin, M.D., the 135th President of the Massachusetts Medical Society, succeeded James S. Gessner, M.D., at the Annual Meeting in April.

Photos on this page by Doug Bradshaw



A Bold Statement for Public Health

Your House of Delegates, at the 2017 Annual Meeting, voted overwhelmingly to support a pilot supervised injection facility (SIF) program in Massachusetts under the direction of a state-led task force. A SIF allows users of illicit narcotics to bring their drugs and inject themselves under medical supervision, rather than down the proverbial dark alley. Before the vote, the Society had conducted a detailed analysis of the impact of SIF facilities elsewhere.

At first, this seems counterintuitive. Many not in attendance at the HOD were surprised — members of the public, legislators, regulators, and even some MMS members. However, I believe that the strong HOD support shows that MMS members are committed to public health and not reticent to make difficult decisions to save lives.

The evidence is clear. The report by the MMS concluded that in other countries, SIFs save lives by bringing critical interventions closer to those in need. Data show that when users have SIF access, they are more likely to seek treatment for their substance abuse. Additionally, SIFs may help prevent transmission of diseases associated with injectable drug use, and help protect persons who inject drugs from related crimes. In communities where SIFs began amidst sizable opposition, that opposition became a strong supportive voice once the positive results were clear.

SIFs aren't the only solution to the opioid crisis, but they represent an additional step toward saving lives. MMS members will continue to be confronted by difficult choices as we advocate for our patients, as we confront public health crises, and as we speak out for the underserved. I feel confident that when presented with convincing data, we will consider novel actions that help us achieve the common goal.

— Henry L. Dorkin, M.D.

“This Abominable Traffic”: Physicians’ Perspectives on Slavery and the Origins of Present-Day Health Disparities

BY LUCY BERRINGTON, M.S.

Preventing slaves from dying of cholera was a matter of humanity as well as economic self-interest, a physician told slaveholders in 1832. “You have reason to be seriously apprehensive of great mortality upon your plantations, unless you take timely measures to guard against the evil,” wrote Christopher Yates, M.D. — a man who described himself as accustomed to the backlash that his medical advice tended to incite. Dr. Yates’s recommendations included improving slave dwellings, observing slaves stealthily for signs of illness, and persuading slaves that cholera was mortal only to “the dissipated, the lazy, and the filthy.”

That guide for slaveholders (*Advice to the Planters of the Southern States*) is part of a searching online exhibit created by the Center for the History of Medicine at the Francis A. Countway Library of Medicine (an alliance between Boston Medical Library, the official library of the MMS, and Harvard Medical Library). “This Abominable Traffic: Physicians on Slavery” draws on the library’s rare book and manuscript collections, which include physicians’ accounts of slavery and racism. “Physicians were some of the most well-traveled individuals of their day and had many opportunities to witness slavery in the West Indies and United States,” says Jack Eckert, the librarian who curated the exhibit.

The exhibit reveals a profession whose members encountered slavery in different ways, active and passive, and responded to it just as variously. In several accounts, the writer’s disgust is evident. “The ‘breeding’ of the human species is carried on just as that of cattle is carried on,” wrote Marshall Hall, an English physician who traveled in America in 1854. Some physicians, however, were using “scientific racism” to justify slavery; John Van Evrie, M.D., argued in the 1850s and ’60s that slavery was the “normal condition” of an “inferior race.” Others occupied a conflicted middle ground. *A Portraiture of Domestic Slavery* by physician Jesse Torrey included “reflections on the practicability of restoring the moral rights of the slave, without impairing the legal privileges of the possessor.” Dr. Torrey’s 1817 narrative included accounts of “free coloured people” in Delaware attacked in the night, kidnapped, and sold to slave dealers.

The exhibit illuminates the historical origins of contemporary

health determinants, says Scott Podolsky, M.D., professor of Global Health and Social Medicine at Harvard Medical School, and director of the Center for the History of Medicine. “We all share the legacy of slavery and its impact on present health care disparities. We also support ongoing examination of the history of the Harvard faculty and how they thought about race itself,” says Dr. Podolsky, who chairs the MMS Committee on History. The exhibit was conceived to complement a symposium on slavery and public health at the Harvard T. H. Chan School of Public Health. “There’s been a general movement over the past few years among education institutions in the U.S. to investigate their historic ties to slavery and its legacy,” says Eckert. The exhibit concludes on a relatively hopeful note, commemorating some of the earliest African Americans to be awarded medical degrees, immediately after the Civil War — physicians born not into slavery but of it.



Images courtesy of the Countway Library of Medicine

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Got Customer Service? Six Keys to Improving the Patient Experience

BY JILLIAN PEDROTTY, M.H.A.
SPECIALIST, PPRC

How does developing the customer service skills of your team improve health care? And why does it matter? At the Physician Practice Resource Center (PPRC) we team up with practices across Massachusetts to identify and analyze challenges and suggest what could work better in each case. As the health care industry evolves and patients become more selective, leaders in health care organizations agree that improving the patient experience is key. What does that mean exactly and how can we approach it?

The Beryl Institute, a global thought leader on this topic, defines the patient experience as the “sum of *all* interactions, shaped by an organization’s culture, that influence patient *perception* across the continuum of care.” Every interaction a patient has — calling a practice for the first time, scheduling an appointment, completing their visit, obtaining their prescriptions, and all other encounters in between — can impact their overall impression of the practice. A negative impression will tarnish a patient’s experience, and in today’s world of social media reviews, potentially other people’s, too.

Encouraging your administrative and clinical practice support staff to have a customer service

mentality can profoundly improve patients’ experience, and can also benefit the operations, efficiency, and culture of your practice. This is an opportunity for everyone in the practice to think about their personal interactions with patients, how those interactions influence the patient experience, and how they can play an active role in improving it.

These six pillars of excellent customer service are straightforward approaches that may tend to get lost or forgotten in busy health care practices:

- 1 Put patients first:** It can be frustrating for a patient to feel unacknowledged, especially when they aren’t feeling well. Recognize a patient’s presence with verbal feedback and/or eye contact, even if you’re mid-phone call.
- 2 Give patients time to talk:** Taking the time to fully listen and understand what the patient is saying reduces the risk of missing key facts, letting questions go unanswered, and leaving a patient dissatisfied.
- 3 Listen for tone:** The tone of the patient’s voice can provide clues to how they are feeling. Picking up on those clues helps address potential issues and mitigate patients’ irritation.

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4 Be genuinely nice: No one wants to feel unwelcome or as if they are an annoyance. Take the time to think about how you say something and how it could be perceived.

5 Use plain language: To avoid miscommunication and confusion, stay away from health care jargon, including acronyms and clinical verbiage, until you are certain the patient understands the meaning.

6 Be accountable: Be the single source for the patient, and take

ownership of answering questions or assisting with issues. Always seek solutions, and follow up.



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Ensuring Competence and Safe Medical Practice: What to Do About Senior Physicians and Cognitive Decline

BY LUIS T. SANCHEZ, M.D.
CHAIR, MMS COMMITTEE
ON SENIOR PHYSICIANS



Luis T. Sanchez, M.D.

If a physician notices that a respected senior colleague is often forgetful and uncharacteristically irritable, what should he or she do?

It’s a delicate question. No one wants to raise a red flag about a colleague who has dedicated his or her career to patient care. But as the general workforce ages, so do physicians. The medical profession is exploring ways to respectfully address cognitive decline in physicians while prioritizing patient care and safety.

Senior physicians are an integral part of the medical workforce. In the U.S., 23 percent of

physicians are aged 65 and older, and 2 in 5 senior physicians are actively engaged in patient care, reports the AMA in *Competency and the Aging Physician*. In Massachusetts, 15 percent of active licensed physicians are age 65 and over, according to the Board of Registration in Medicine. The MMS Committee on Senior Physicians advocates for this physician constituency. The committee is exploring the issue of

cognitive decline faced by aging physicians and how this issue affects their competence and confidence as medical practitioners.

Facing Cognitive Decline

As physicians age, they bring to their practices many positive attributes and accomplishments: wisdom, insight, resilience, compassion, and tolerance in stressful situations. Yet some senior

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Does This Patient Need Clearance for Exercise?

Revised Medical Guidelines Make It Easier to Get Up and Out

BY MIGUEL CONCEPCION, M.D.,
AND ELIZABETH ALT, M.D., M.P.H.

Summer in New England is packed with opportunities to be physically active. For physicians, this is a good time to familiarize yourselves with updated guidelines on who needs medical clearance before exercising.

The updated recommendations from the American College of Sports Medicine (ACSM) may make it easier for patients to become physically active. The revised Recommendations for Exercise Preparticipation Health Screening use current physical activity status as the starting point: Has the person undertaken planned, structured physical activity for at least 30 minutes at moderate intensity on at least three days a week for at least the previous three months?

In brief: Physically active patients who are asymptomatic and without cardiovascular, metabolic, and renal disease may continue with moderate or vigorous physical activity without medical clearance. Physically inactive patients of the same health status may proceed with light to moderate physical activity without medical clearance. These patients may progress according to ACSM exercise prescription guidelines. If patients have known cardiovascular, metabolic, or renal disease, they may need medical clearance

for physical activity. Patients who are symptomatic should seek medical clearance before starting or returning to physical activity.

Previous Recommendations Were Barrier to Exercise

The outdated recommendations emphasized cardiovascular disease (CVD) risk factors. Under those guidelines, 95 percent of men and women older than 40 were advised to consult a physician before exercise.

This approach may have caused an overabundance of referrals for medical clearance, creating a potential barrier to exercise without improving safety outcomes. Studies have demonstrated the overall low incidence of sudden cardiac death (SCD) and acute myocardial infarction (AMI) associated with exercise. Multiple studies have shown an inverse relationship between regular (habitual) physical activity and SCD and AMI. Increased risk is seen primarily in those who engage in episodic physical activity.

How New Guidelines Affect Sample Patient

Here's how the change in guidelines, introduced in November 2015, affect a 46-year-old man with a total cholesterol of 220 mg/dl who wants to start a regular fitness program:



Paul Noth/The New Yorker, © Condé Nast. Used with permission.

- Under the new guidelines, he does not need medical clearance, regardless of his baseline activity level. If he had type 2 diabetes or any cardiac or renal disease medical clearance would be recommended.
- Under the old guidelines, he would have been categorized as moderate risk (asymptomatic

with at least two CVD risk factors, age and hyperlipidemia) and referred for a medical exam. If he were symptomatic or had known cardiovascular, metabolic, or pulmonary disease he would have been categorized as high risk and advised to undergo both a medical exam and a diagnostic exercise test.

Flowchart: Preparticipation Health Screening

This printable infographic by the ACSM is designed to guide health care and fitness professionals. It cannot be altered or republished without permission.

<http://goo.gl/Riepwq>

Optimizing Technology to Boost Patient Immunization Rates

BY LUCY BERRINGTON, M.S.

Automated vaccination reminders can substantially raise adult vaccination rates and improve practice efficiency, as demonstrated by a Worcester physician who has been honored for his impact on adult immunization in and beyond Massachusetts.

Lloyd D. Fisher, M.D., pioneered at Reliant Medical Group the use of EHR to automate vaccination reminders. As assistant medical director for informatics, Dr. Fisher incorporated clinical decision support tools to generate reminders at every patient visit and flag patients who were due for vaccinations. He also collaborated with EHR developers at Epic to improve

their vaccination forecasting tools. Dr. Fisher received a Massachusetts Adult Immunization Champion Award at the Massachusetts Adult Immunization Conference in Marlborough in April.

Vital Signs talked with Dr. Fisher about how practices can use EHRs to improve vaccination rates and practice efficiency.

For physicians starting on this now, what is the time investment? "The overwhelming majority of practices are using EHRs and have forecasting available. This programming is now standard for Epic, and other vendors have similar features. It's up to the physician leaders to push the IT

department to turn on these features and make sure there are clinical people validating it — physicians and nurses who are involved in setting it up. At smaller practices that don't have an IT infrastructure, it's about pushing the vendor to do that work."

What's the return on that upfront investment? "We're saving time on the frontline, so physicians don't have to think about which immunizations are due. Previously, there were times a dose didn't count because it was given too soon, or couldn't be given because certain vaccines interact with each other. Certain vaccines are required only for certain patients. The computer can look through the chart

and identify those patients. The recommendations for the pneumococcal vaccines are so complex that without a computerized system you could be missing a lot. We're saving staff time; you have the patient in the office, and you're not wasting time bringing them back in later for an immunization."

How readily did your colleagues embrace this? "A lot of physicians, myself included, initially didn't feel they needed it. Vaccinations are uniquely positioned to be really good for electronic alerts, though, because there's no clinical decision making involved. We're at the point now that our physicians completely trust the system."

Marijuana Legalization: Controversial Issues Call for Flexible Advocacy

BY BRENDAN ABEL, MMS
LEGISLATIVE COUNSEL

When a medical society opposes the legalization of recreational marijuana, and recreational marijuana is legalized anyway, what should that medical society do? If it's the MMS, it remains at the table, working to ensure that the new law comes with public health protections and research into the effects of legalization.

In November 2016, voters opted to legalize recreational marijuana in Massachusetts, despite opposition from the Medical Society and many other health care-related stakeholders. But the advocacy story did not end with the passage of Ballot Question 4. Through the wisdom of the House of Delegates, who revisited the issue at the Interim Meeting in December 2016, the Medical Society adopted a new policy that allowed us to stay involved.

The Society's policy shift was prescient. The legislature has indicated a strong willingness to reopen the ballot initiative and amend certain provisions that are causing concern, such as the tax rate and the oversight structure, and to add public health protections. The Medical Society advocacy team, including our physician leadership and staff, has engaged with the legislators as they work on amending the law that voters supported in November.

The Medical Society identified priorities for guiding an evidence-based approach to addressing the potential deleterious effects of legalization. These priorities include:

- Preventing youth access to marijuana
- Directing funding to conduct research on the effects of recreational marijuana, including impaired driving

- Promoting education about the health effects of recreational marijuana
- Setting safety and quality standards for recreational marijuana use

The Medical Society staff and leadership reviewed nearly 100 bills that were assigned to the legislature's Joint Committee on Marijuana Policy and determined which bills best aligned with these priorities. Eight bills emerged from that review. Each bill addresses specific charges raised by the MMS membership, including strengthening public health education and prevention efforts, amending the oversight structure, and promoting further research to better understand the effects of the drug on health and development, as well as the impacts of legalization.

The Medical Society leadership and staff have been in close touch with the key leaders in the state house to monitor developments and offer expertise. Dr. James Gessner, past-president, testified in April before the legislature at a special hearing of the Marijuana Policy committee in Shrewsbury. Dr. Gessner emphasized the opportunity to craft a best-in-the-nation marijuana oversight and public health structure. "The Massachusetts legislature has a rich history of being on the forefront of public health policy, from vaccines to tobacco," he said.

An omnibus bill incorporating all amendments to the recreational marijuana law is expected to reach the governor's desk this summer. The Medical Society will continue to work to ground that bill in the strongest possible public health protections until it is signed into law.



Health Care Costs

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evaluated the factors influencing patients' decision making on where they seek care. "Physicians' referrals are a key piece to the puzzle," says Amy Lischko, D.S.c., M.S.P.H., associate professor at TUSM, and co-PI on the project. "Patients reported that they would seek care in lower-cost settings if their physician referred them there."

Next question: What influences physicians' referrals? "This has not been well studied," says Dr. Lischko. "What do physicians feel is their responsibility tied to patients' affordability? What would motivate them to consider patients' costs?" An effective solution would be "not cumbersome," she says — for example, a tool incorporated into the EHR that merges the patient's health insurance information with a physician's referral considerations. Dr. Lischko is exploring the potential for a study that explores how doctors' advice and actions can affect patient treatment decisions, leading to higher value care.

"There is increasing recognition in the medical profession of the need to consider cost sharing, that this is a relevant factor in patient care decision making," says Paul Hattis, M.D., J.D., M.P.H., also an associate professor at Tufts. The Choosing Wisely

campaign from the ABIM Foundation, for example, aims to help physicians talk with patients about avoiding wasteful or unnecessary medical tests, treatments, and procedures. "An extension of such a campaign could encourage patients to forego care in more expensive settings that offer no additional quality benefit," says Dr. Hattis.

The Value of Talking about Cost

Typically, physicians may not have the time or the tools to consider patient costs during a visit. In a 2016 study that looked at three diseases associated with high out-of-pocket payments, 32 percent of patient visits involved a conversation about costs, sometimes including money-saving strategies, such as affordable prescriptions. The findings highlight the potential for physicians to help manage patients' financial burden, the researchers wrote in *BMC Health Services Research*.

The Society is supporting a bill that would require insurers to make drug formularies available online for viewing by patients and physicians, potentially facilitating those conversations. Some barriers to cost-based decision making, however, are outside physicians' control. Referrals may be influenced by a lack of access to electronic records at some practices, and network restrictions that place value-based community care beyond patients' reach.

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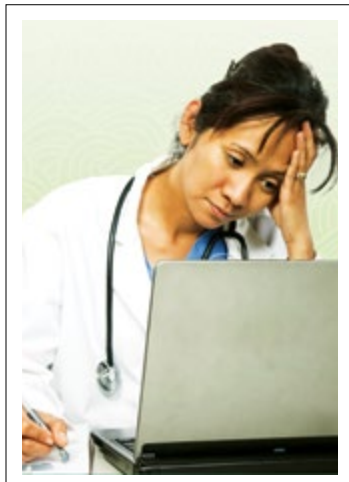
Turning Down the Heat: What to Do About Physician Burnout

BY JAIDEV DASGUPTA, M.S., PH.D.
PROJECT LEADER, MANAGING WORK-
PLACE COMPLEXITY, PHS

“The effects of burnout and depression on medical trainees are growing,” writes Dr. Miguel Paniagua in *100 Days of Rain: A Reflection on the Limits of Physician Resilience*. “[M]any health care practitioners silently bear the burden of not only struggling to care for their patients, but also for themselves” (*NAM Perspectives*, 2017). This is the current state of affairs of the health care system. More than half of practicing physicians are experiencing burnout, a state of emotional exhaustion that leads to compassion fatigue and the loss of professional effectiveness, according to a recent study in the *Lancet*. This, in turn, affects patients’ experience, eroding satisfaction and potentially the quality of care.

Awareness of the burnout phenomenon has grown in the past decade, and despite efforts to rein it in, the burnout rates continue to rise. Currently, there are two approaches to addressing burnout. One, the individual approach, is to enable doctors to take care of their own mental and physical health in order to cope with mounting challenges in the workplace. This focuses on building resilience, the use of mindfulness techniques, reducing stress, tapping into peer support, and so on. The second perspective sees burnout as arising from faulty organizational structures and burdensome technologies, such as EHRs. The focus here is on redesigning workplace processes and tools. While both these approaches have yielded some positive results, their long-term efficacy and scalability have not been established.

Other aspects of the burnout problem deserve attention. One of these is community. Doctors must be viewed as part of the community they serve. A primary care physician serving in an underfunded, understaffed community health care center may be at



higher risk of burnout and depression — a risk that is unlikely to be mitigated unless the conditions of the workplace change. It also matters that health care delivery has become an industry — which, like any other industry, operates with the mantra “more with less.” When maximizing profit is the motive, physician burnout is a likely side effect.

The burnout epidemic is not simply a result of individual or organizational issues. Ailing physicians are a sign of a system that needs help at multiple levels. The health care system operates in the context of related entities that can affect its performance: community, industry, regulations, and the overall socio-cultural environment. That’s why at Physician Health Services we are developing a burnout intervention program that takes a broader perspective, exploring solutions that go beyond the individual, team, or organization. Addressing physicians’ work-related illness may need a paradigm shift toward an ecological approach that recognizes those levels of influence and their effects on physicians’ well-being.

Dr. Dasgupta is an [Encore Fellow at PHS](#) ([Encore Fellowships match seasoned professionals with social purpose organizations; ESCNE.org](#)). He is the author of *In Search of Immortality* (Manohar, 2015). In the recent past he was a scientist, technologist, and entrepreneur.

Cognitive Decline

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physicians face memory loss, the diminution of executive functions and cognitive processing abilities, or other faculties integral to competent practice in our fast-paced health care environment. Sometimes physicians are unable to self-assess, manifesting as episodes of denial or lack of interest.

Screening and Warning Signs

Age-based screening of cognitive competence in physicians is in place in some medical facilities. Such screening must take into account the significant differences in cognitive and physical demands associated with practice specialty and whether the physician is functioning in a solo or group setting.

Many group practices or hospital settings offer credentialing processes, peer reviews, or other means that ensure physicians perform according to expectations. The Massachusetts Board of Registration in Medicine requires physicians to recognize and respond appropriately to performance deficits when observed in colleagues.

Warning signs may include:

- Behavioral changes, such as increased irritability, depression, and alcohol or substance abuse
- Professional slips, such as problems with history-taking or patient management, errors in

prescribing, shortcomings with physical exams, diminished record keeping, and communication issues

A sentinel event might bring together those close to the physician to consider appropriate action steps. It is essential to address the physician with respect and caring, while encouraging him or her to consider healthy options. These options may include modifying their professional role, reducing practice responsibilities by decreasing the number of patients, increasing support staff, or transitioning into retirement.

Available Resources

Identifying adverse medical or psychosocial factors is the first step toward implementing changes, including confidential, peer review protected programs, such as those offered by Physician Health Services. Another useful resource is the *MMS Guide to Practice Transition or Retirement* published by the Physician Practice Resource Center.

The MMS Committee on Senior Physicians encourages physicians to be self-aware and to counsel their colleagues who experience cognitive decline issues. A quick response when faced with potential safety and competency concerns remains the best course. For additional information, contact Chew-Hoong Koh, staff liaison, at ckoh@mms.org.

Residents and Fellows Completing Training in June 2017: Access Your Free MMS Membership

- The MMS offers free membership for your first year in practice. Maintain benefits like your *New England Journal of Medicine* subscription whether or not you’re staying in Massachusetts. For more information, contact mmsprocessing@mms.org or (800) 322-2303, ext. 7495.
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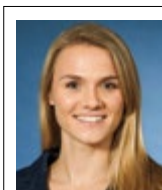
GEORGE M. ABRAHAM, M.D., M.P.H., F.A.C.P. (Christian Medical College Ludhiana, '87, residency: Saint Vincent Hospital), has been named chair-elect of the Board of Governors and a member of the Board of Regents of the American College of Physicians (ACP). Dr. Abraham is professor of medicine at the University of Massachusetts Medical School, associate chief of medicine at Saint Vincent Hospital, past president of the Worcester District Medical Society, and a former trustee of the MMS. Dr. Abraham is also a fellow of ACP and a member of the Board of Registration in Medicine.

ARLAN F. FULLER, M.D. (Harvard Medical School, '71, residency: MGH, BWH), has been appointed Telemachus and Irene Demoulas Family Chair for Women's Health at

Lahey Health. Dr. Fuller is the clinical vice president for Oncology Services Integration and Academic Affiliations at Winchester Hospital, a member of Lahey Health. Dr. Fuller, long-time chief of gynecologic oncology at MGH, received the Massachusetts Medical Society's 2015 Women's Health Research Award.

JAMES D. THOMAS, M.D. (Medical College of Wisconsin, '91, residency: St. Vincent Medical Center/The Toledo Hospital), an emergency medicine practitioner at Good Samaritan Medical Center in Brockton, St. Anne's Hospital in Fall River, and several other community hospitals, has been elected to the Board of Directors of the American Board of Emergency Medicine (ABEM). Dr. Thomas is an ABEM Oral Examiner and item writer for the ConCert™ Examination.

Members on the Move



Katherine Goble, M.D.



Michele Pugnaire, M.D.



Jennifer Tseng, M.D., M.P.H.

KATHERINE (KATIE) H. GOBLE, M.D. (UMass Medical School, '14, residency: MGH), is joining the faculty at the University of California Los Angeles as a pediatric hospitalist. Dr. Goble was previously a vice chair of the MMS Medical Student section. Her major interests include medical education and working with Spanish-speaking patients, and she is looking forward to continuing both in LA.

MICHELE P. PUGNAIRE, M.D. (McGill University Faculty of Medicine, 1980, residency: UMass Medical School), is stepping down from her role as senior associate dean for educational affairs at UMass Medical School (UMMS). Dr. Pugnaire is remaining on the faculty as professor emerita and will continue to teach, and sponsor the Dominican Republic Batey Health Initiative. Dr. Pugnaire

has been a longstanding champion of medical education at UMMS. "She has been the driving force in many of our successes," said Terence R. Flotte, M.D., executive deputy chancellor, provost, and dean of the School of Medicine.

JENNIFER F. TSENG, M.D., M.P.H. (University of California San Francisco, 1995, residency: MGH), has been appointed chief of surgery at Boston Medical Center (BMC) and chair of the Department of Surgery at Boston University School of Medicine (BUSM). Dr. Tseng, currently a professor of surgery at Harvard Medical School, comes to BMC/BUSM from the Beth Israel Deaconess Medical Center. Dr. Tseng is a highly regarded surgical oncologist and gastrointestinal surgeon.

Please send submissions to vitalsigns@mms.org.

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.

Mustafa I. Adham, M.D., 93; West Springfield, MA; died April 15, 2017.

George L. Blackburn, M.D., Ph.D., 81; Boston, MA; University of Kansas School of Medicine, Kansas City; died February 20, 2017.

Jane Shohl Colburn, M.D., Ph.D., 85; Westford, MA; University of Cincinnati College of Medicine; died August 11, 2003.

J. William Dolan, M.D., 81; Tufts University School of Medicine, Boston; died February 26, 2015.

Elias C. Dow, M.D., 89; Brookline, MA; Tufts University School of Medicine, Boston; died April 17, 2017.

Hikmet N. Emmanuel, M.D., 87; Concord, MA; Royal College of Medicine, Baghdad; died September 1, 2013.

Victor D. Fedorov, M.D., Ph.D., 32; Boston, MA; Weill Cornell Medical College, New York City; died March 12, 2017.

Lawrence Hessman, M.D., 79; Andover, MA; SUNY Downstate Medical Center, Brooklyn; died July 11, 2016.

Samuel Kaplan, M.D., 100; Newton, MA; died November 17, 2014.

Ganson Purcell Jr., M.D., 80; Amesbury, MA; Columbia University College of Physicians and Surgeons, New York City; died March 16, 2017.

John C. Ready, M.D., 93; Elizabeth, ME; Tufts University School of Medicine, Boston; died March 30, 2016.

Lauren R. Zeitels, M.D., Ph.D., 32; Boston, MA; Johns Hopkins University School of Medicine, Baltimore; died March 12, 2017.

ACROSS THE COMMONWEALTH

District News and Events

WEST CENTRAL REGION

Hampden — Executive Board Meeting. Tues., Sept. 12, 6:00 p.m. Location: HDMS Office, West Springfield.

Hampshire/Franklin — CT River Boat Cruise. Sat., Jul 29, 1:15–3:00 p.m. Location: Northfield Mountain Visitor Center, Northfield. Bring your family and join your colleagues aboard to enjoy a relaxing and informative journey down New England's

great river, the Connecticut River.

West Central Regional Office: (800) 522-3112 or csalas@mms.org.

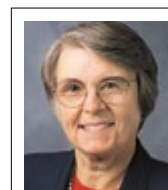
NORTHEAST REGION

Charles River — Family Outing. Sat., Aug. 26. Location: New England Aquarium. More information to follow; watch for the mailing.

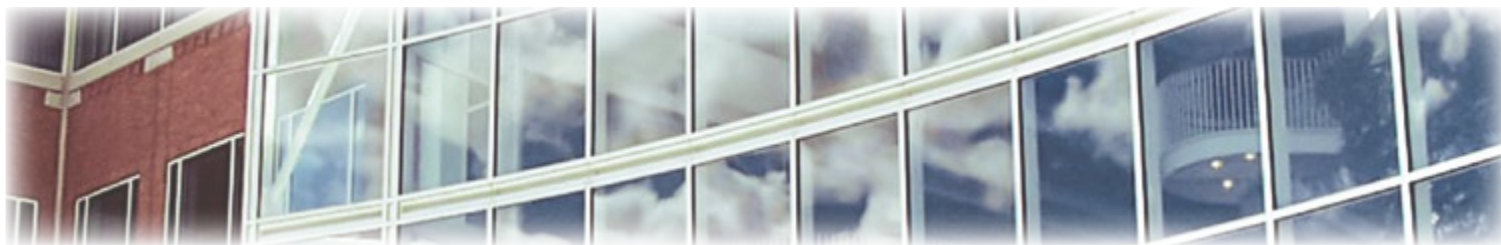
Northeast Regional Office: (800) 944-5562 or mjussaume@mms.org or lhoward@mms.org.

MMS Mourns Virginia Latham, M.D.

Virginia T. Latham, M.D., a past president of the Massachusetts Medical Society, died April 21, 2017, age 74. Dr. Latham's legacy includes remarkable contributions to the medical and patient communities over several decades. In 2016, she became the second person ever to be awarded the MMS Presidential Citation, recognizing "a career in medicine exemplary of the highest traditions, ideals, and aspirations of the Massachusetts Medical Society," said then-President James S. Gessner, M.D. Dr. Latham joined the Medical Society in 1983 and served in numerous capacities. In 2000, she became the third woman elected to lead it. She was instrumental in the Society's advocacy for patient safety and privacy, and in the appointment of the current editor of the *New England Journal of Medicine*. Dr. Latham received her medical degree from Harvard Medical School in 1981.



Virginia Latham, M.D.



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> **Cognitive Decline in Senior Physicians**
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> **A Guide to Boosting Adult Immunization**
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MASSACHUSETTS
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VOLUME 22, ISSUE 6, SUMMER 2017

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MMS AND JOINTLY PROVIDED CME ACTIVITIES

LIVE CME ACTIVITIES

Unless otherwise noted, event location is MMS Headquarters, Waltham. Visit www.massmed.org/cme/events.

Norfolk County Safe Prescribing and Dispensing Conferences

Thursday, September 14, 2017, The Lantana, Randolph, MA

ONLINE CME ACTIVITIES

Go to www.massmed.org/cme

Risk Management CME

Electronic Health Records Education (3 modules)

- Module 1 — EHR Best Practices, Checklists and Pitfalls
- Module 2 — Making Meaningful Use Meaningful: Stage 1
- Module 3 — Making Meaningful Use Meaningful: Stage 2

End-of-Life Care

- Legal Advisor: An Introduction to Advance Directives
- End-of-Life Care and Non-Disclosure: Case Study
- Starting the Conversation about End-of-Life Care with Patients
- End-of-Life Care (3 modules)
- Principles of Palliative Care and Persistent Pain Management (3 modules)

Pain Management and Opioid Prescribing

- MassPAT: Incorporating the New PMP into Your Practice

- Managing Pain Without Overusing Opioids
- The Opioid Epidemic: Policy and Public Health (6 modules)
- Principles of Palliative Care and Persistent Pain Management (2 modules)
- Opioid Prescribing Guidelines in Practice
- Opioid Prescribing Series (6 modules)
- Identifying Potential Drug Dependence and Preventing Abuse (*Legal Advisor*)
- Managing Risk when Prescribing Narcotic Painkillers for Patients (*Legal Advisor*)

Medical Marijuana (4 modules)

- Module 1 — Medical Marijuana: An Evidence-Based Assessment of Efficacy and Harms
- Module 2 — Medical Marijuana in the Commonwealth: What a Physician Needs to Know
- Module 3 — Medical Marijuana in Oncology
- Module 4 — Dazed and Confused: Medical Marijuana and the Developing Adolescent Brain

Additional Risk Management CME Courses

- Talking to Patients About Gun Safety
- Initiating a Conversation with Patients on Gun Safety

- Intimate Partner Violence: The Clinician's Guide to Identification, Assessment, Intervention, and Prevention
- Efficacy of FIT-FOBT for Colorectal Cancer Screening
- Prostate Cancer and Primary Care
- Cancer Screening Guidelines (3 modules)
- Transitioning to Alternative Payment Models
- Payer Audits and Payment Recoupments
- Understanding Clinical Documentation Requirements for ICD-10
- ICD-10: Beyond Implementation
- Impact of Effective Communication on Patients, Colleagues, and Metrics (2 modules)
- Effective Chart Review for Quality Improvement

Additional CME Courses

- Helping Patients with COPD Breathe Easier
- Carbon Monoxide Poisoning
- Genetically Modified Foods: Benefits and Risks
- Just a Spoonful of Medicine Helps the Sugar Go Down: Improve Management of Type 2 Diabetes
- Weighing the Evidence on Obesity



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

FOR ADDITIONAL INFORMATION AND REGISTRATION DETAILS, GO TO WWW.MASSMED.ORG/CMECENTER, OR CALL (800) 843-6356.