

VITAL SIGNS



MASSACHUSETTS
MEDICAL SOCIETY

*Every physician matters,
each patient counts.*

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DPH Seeks Middle Ground in Regulations on Industry Gifts to Physicians

BY TOM WALSH

Proposed rules released in December by the Massachusetts Department of Public Health (DPH) that would regulate gifts to physicians from drug and medical device manufacturers (see box on page 2) have sparked a wide range of reactions.

The physician community has expressed cautious support of the draft regulations, while commercial interests assert that they are too strict, and consumer activists say they are not strong enough in implementing a law passed by the Legislature last year.

The proposed regulations are meant to expand and clarify the language contained in the Cost Containment, Transparency, and Efficiency in the Delivery of Quality Healthcare Act enacted in August, according to Melissa J. Lopes, DPH deputy general counsel.

The DPH describes its proposal as the "most stringent" among similar measures adopted by six other states (California, Maine, Minnesota, Nevada, Vermont, and West Virginia) and the District of Columbia.

The proposed regulations were scheduled for debate at public hearings in Boston and Worcester in January, just after this issue of *Vital Signs* went to press. Bruce S. Auerbach, M.D., MMS president, said the draft proposal appears to be "something we can live with." He added, "I see no problem with restricting these industries' options for big dinners and golf outings."

Dr. Auerbach cautioned, however, that there is no need to make the proposals any stricter. To do so, he said, could "hurt Massachusetts and its economy, without any gain for the public." The MMS was scheduled to deliver testimony at the January hearings.

Legislative Advocacy Helped

Earlier this year, the MMS successfully convinced state lawmakers that the originally filed legislation, which would have forbade physicians to receive virtually anything of any value from companies, would have impeded publication of important medical research and the viability of continuing medical education programs.

In March testimony to the Joint Committee on Health Care Financing, the Society supported the notion of preventing "undue influence on the prescribing patterns of physicians" by manufacturers, but called the Senate version of the bill "over-broad." Eventually, the Legislature arrived at language regulating gifts, but not banning all exchanges with physicians, and left the fine-tuning to the DPH.

Gifts Worth More than \$50 to Be Disclosed

The proposed DPH regulations would require that drug and device manufacturers make public disclosure of all payments of more than \$50, except those made to providers for genuine research projects and clinical trials. The positions of those most affected by the proposed regulations vary regarding the predicted impact on physicians, patients, and the state's economic well-being.

The Massachusetts Biotechnology Council responded to the release of the draft regulations with concern that Massachusetts would become the state with the strictest regulations and that the rules would hamper the state's ability to attract and keep biotech companies.

The Pharmaceutical Research and Manufacturers of America (PhRMA), which represents the country's pharmaceutical research and biotechnology companies, called Gov. Deval Patrick's

Medical Blogs May Shape Health Care Reform

BY FRANK FORTIN

Health care blogs have quickly emerged from their humble origins as idiosyncratic personal online journals into a force that could influence the course of national health reform.

Most blog writers have an opinion to share and aren't shy about it. Blogs also offer readers the chance to reply with their opinions. This online "town meeting" may be the blogs' most important contribution to the health care debate here and across the country.

Several regional blogs already have a big voice in the national debate:

Running a Hospital. Author: Paul Levy, president of Beth Israel Deaconess Medical Center. Levy writes about health policy, hospital issues, and major stories of the day. Updated daily. runningahospital.blogspot.com

A Healthy Blog. Authors: Staff at Health Care For All. Reports and comments on health policy developments in Massachusetts, especially implementation of Chapter 58. Updated daily. blog.hcfama.org

Commonhealth. Authors: Guests from government, medicine (including MMS physicians), business, and academia. Authors comment on health care policy and state health care reform. Updated daily. commonhealth.wbur.org

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PRESIDENT'S MESSAGE



Mass In Motion: We're All Responsible

This message is co-authored by me and John Auerbach, the Massachusetts Commissioner of Public Health, to emphasize

how the important initiative described below supports the Society's public health and preventive efforts.

Every New Year, people resolve to eat healthier, exercise more, and follow their doctor's advice. Yet we are seeing an unprecedented increase in overweight children and adults in our state.

To help turn resolutions into success, the Massachusetts Department of Public Health (DPH), in partnership with the MMS and numerous other organizations, recently launched Mass In Motion — a coordinated anti-obesity campaign.

Why is healthy weight getting so much attention? At present, almost 60 percent of the U.S. adult population is overweight, and childhood obesity rates have nearly tripled since 1980. Adult rates for type 2 diabetes in Massachusetts are almost twice as high as they were a decade ago, not to mention that overweight contributes to heart disease, some cancers, and arthritis.

The primary causes are simple: not enough physical activity (too much TV and computer time) and not enough fruits and vegetables (too much junk food).

Much good work has been done already to promote healthy weight, including the MMS's "Your Health First" healthy weight campaign. Informational materials for physicians and the public, available at www.massmed.org/yourhealthfirst, include

patient handouts on nutrition and physical activity and prescription pads intended to remind patients that their physicians' lifestyle recommendations are as important as medication prescriptions.

Early action steps for Mass In Motion include:

- A statewide public information campaign involving Gov. Deval Patrick and other champions
- An interactive website (www.mass.gov/massinmotion) with healthy living tips
- Proposed regulations that require periodic BMI screening in schools and reporting of results to parents
- Proposed regulations that require certain restaurants to prominently post calorie information
- A requirement that state agencies that purchase large quantities of food follow specific nutritional standards
- Expansion of the DPH worksite wellness program
- Grants to communities for supporting active living and healthy eating

Overweight and obesity must be comprehensively addressed through interventions in physicians' offices and in the community. We encourage Massachusetts physicians to support Mass In Motion by emphasizing healthful behaviors to all their patients.

Bruce S. Auerbach, M.D.

— Bruce S. Auerbach, M.D.



John Auerbach

— John Auerbach

Gift Regulations

continued from page 1

signing of the legislation in August "deeply disappointing — and very likely damaging for medical partnerships, clinical research, and patients in Massachusetts."

Ken Johnson, PhRMA senior vice president, added, "The language that would require public disclosure of payments between pharmaceutical research companies and health care providers could chill ongoing clinical research in the state."

The Advanced Medical Technology Association (AdvaMed), which represents manufacturers of medical devices, said it supports "appropriate disclosure

of financial relationships with physicians so that patients receive useful, meaningful information that provides full context for any payments physicians may receive from medical technology companies."

At the same time, though, AdvaMed advocates a federal solution to such reporting, declaring that "a patchwork of state regulations will likely cause confusion and create unnecessarily burdensome and costly requirements" for companies that sell products in multiple states.

Patient Relationship a "Public Trust"

"There is a public trust involved in the patient relationship with the health

continued on page 8

Summary of the Proposed Gift Regulations

Who Would Be Affected?

- Those who prescribe drugs
- Those licensed to provide health care
- Partnerships or corporations comprised of the above

What Would Be Prohibited?

General:

- Grants, scholarships, subsidies, consulting contracts, or education items in exchange for prescribing or disbursing prescriptions or medical devices
- Entertainment or recreational items of any value
- Cash payments or equivalents, except as compensation for bona fide services
- Complimentary items such as pens, coffee mugs, etc.
- Meals as part of an entertainment or recreational event
- Meals offered without an informational presentation by a pharmaceutical or medical device marketer
- Meals outside of a caregiver's office, hospital, academic medical center, or specialized training facility
- Meals provided to a caregiver's spouse or other guest

CME, Conference, and Meeting Prohibitions:

- Financial support (travel, lodging, personal expenses) for non-faculty physicians
- Direct payment of meals
- Sponsorship of CME not compliant with accepted ACCME standards for commercial support

What Is Permissible?

- Modest meals with informational sessions in clinical training settings
- Sponsorship of meals at professional meetings
- Reasonable compensation for a genuine research project or clinical trial
- Reimbursement of reasonable costs for medical device training with a written agreement to buy the device
- CME, conference, or meeting scholarships for residents and interns
- Conference faculty compensation and reasonable expenses
- Provision of peer-reviewed journals or other academic, scientific, or clinical information

Disclosure Requirements

- Pharmaceutical and medical device manufacturers must report any "fee, payment, subsidy, or other economic benefit worth at least \$50 to any physician or other covered person or corporation in connection with sales and marketing activities."

Note: It is not clear whether the \$50 limit is for one transaction or cumulatively during the reporting period.

Enforcement

- Violators are subject to fines of up to \$5,000 per transaction, occurrence, or event. Fines and reporting are the responsibility of the industry, not the physician.

Source: Massachusetts Department of Public Health

Note: The preceding list is not all-inclusive, and the regulations are not final. Items listed as "permissible" should not be construed as legal advice.

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New Approaches to Achieving Economies of Scale in Small Practices

Medical service organizations (MSOs) got a significant boost in the early 1990s when organizations such as PhyCor retained client clinics like the Nalle Clinic in Charlotte, North Carolina, and the Lewis-Gale Clinic in Roanoke, Virginia. The goal of these arrangements was to let physicians be physicians and leave the business side of medicine to the professional business folks.

Unfortunately, all parties learned that the business of medicine is inextricably intertwined with physicians practicing medicine. In the two cases mentioned, the clinics suffered rapid declines in physician population and heavy financial losses. The Nalle Clinic went out of business 10 years after signing on with PhyCor. The Lewis-Gale Clinic survived, but only after losing some of its top physicians and sustaining substantial losses. The entire concept of outside corporate management of medical practices got a black eye.

It's more common now to find practices operating under the guidance of a physician hospital organization (PHO), independent physician association (IPA), or physician organization (PO), all of which provide a venue for collective activities that benefit member practices.

But it isn't always possible for small practices to be part of these larger entities. While certain legislative restrictions prevent independent practices from col-

luding on contracting, there are hardly any barriers to forming a collective or cooperative that could accomplish many of the same goals of the MSOs, without endangering the independence of the participating practices.

In the current environment, one of the only ways to reduce costs is through economy of scale. If a group of small practices determined that certain business operations could be centralized in a cost-effective manner, it would be relatively simple to set up a structure that would encourage participation and create efficiencies.

Any entities participating in such a structure should recognize from the inception that the organization exists to benefit physicians, not to make a profit. Conversely, although the organization would be owned and governed by physician members, it should be run by a qualified businessperson.

This variation on the old MSO model means physicians would work cooperatively to govern the new organization and benefit their practices, rather than contract with a separate profit-driven entity. Control of the organization would be retained by member groups and physicians. Properly formed, this business structure might provide a cost-effective alternative for solo practices and small groups that can't benefit from economies of scale by joining other organizations. **VS**

— Adam Shlager

MMS Surveys: Your Chance to Be a Catalyst for Change

Massachusetts physicians are practicing in an environment characterized by increasing practice costs, declining reimbursement rates, workforce shortages, and growing administrative burdens. Survey research is a critical advocacy tool that allows the MMS to document and address these challenges.

Many of you have probably received at least one survey from the MMS over the years. When we ask you to complete a survey, we are really asking that you, as an expert on the front lines of medicine, provide us with the wisdom we need to align MMS goals and strategies to your interests and needs.

Surveys form the foundation for the Society's leadership role in developing health care policy and advocating for change. Recent MMS surveys, such as highly publicized studies on physician workforce shortages and the cost of

defensive medicine, have brought physicians' opinions to the attention of the public, the media, and government leaders.

By gathering survey data from physicians on topics such as administrative burdens, payment reform, tiering, and patient safety, the MMS advocates for issues that enhance and protect the physician-patient relationship. Your participation in surveys also helps preserve physicians' ability to make clinical decisions for the benefit of patients.

During this defining moment when the entire nation is looking to Massachusetts as a model for health care reform, physician opinions are more important than ever. Although completing a survey takes time, please know that your viewpoints are a catalyst for change. **VS**

— Therese Fitzgerald, Ph.D.

LAW AND ETHICS

New Joint Commission Standards for Disruptive Behavior Now in Effect

Disruptive behavior is one of the more difficult problems health care organizations and providers face. It can be hard to define, as individual cases may involve subjective interpretation of events. Nonetheless, the Joint Commission defines "intimidating and disruptive behaviors" to include "overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities." The Joint Commission goes on to include in the list "reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions."

Recognizing that such behavior can adversely impact patient safety and the overall quality of health care, the Joint Commission set forth new accreditation standards for health care organizations that went into effect January 1. These new standards require that hospitals/organizations have a code of conduct that defines acceptable and disruptive and inappropriate behaviors, and that organizational leaders create and implement a process for managing disruptive and inappropriate behavior.

The Joint Commission also offers a number of suggestions to help organizations deal with the problem and successfully meet the above-mentioned requirements. Closely mirroring many harassment-related policies, these suggestions include:

- Educating all team members regarding appropriate behavior defined by the organization's code of conduct
- Holding all team members accountable for modeling desirable behaviors and enforcing the code of conduct equitably
- Developing and implementing policies that include the following:
 - Zero tolerance for intimidating/disruptive behaviors

- Reducing fear of intimidation or retribution and protecting those who report disruptive behaviors
- Responding to patients who are involved with or witness disruptive behavior
- How and when to begin disciplinary action
- Providing training and coaching for managers
- Assessing staff perception of the seriousness and extent of unacceptable conduct
- Developing reporting/surveillance systems and evaluating the efficacy of such systems
- Intervening as required and implementing progressive discipline plans
- Encouraging interprofessional dialogues to address and overcome ongoing conflicts
- Documenting all attempts to address intimidating and disruptive behaviors

The Joint Commission says "disruptive behavior" includes uncooperative attitudes, condescending language, and impatience with questions.

Physicians are encouraged to take an active role in working with their hospitals and organizations to define acceptable and disruptive behaviors and develop education and implementation plans. Physicians may also want

to revisit their hospital bylaws to ensure due process in the event of a dispute.

For guidance, the MMS publishes resources for members related to self-governance, including the *Model Medical Staff Bylaws* and the *Model Principles for Peer Review*, both available at www.massmed.org. Additionally, keep an eye out for the CME program titled "Managing Workplace Conflict" in May and other courses on leadership and empowering the medical staff. **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.

Disaster Planning for Your Patients and Your Practice

On March 31, the MMS will present a live CME event titled, "Disaster and Primary Care: How to Protect Your Patients and Your Practice." The program is designed to raise awareness about the critical importance of maintaining access to primary care and prescription medications for your patients in the face of a disaster. Internists, family practice physicians, pediatricians, physician assistants, nurse practitioners, and other providers involved in primary care are encouraged to attend.

Participants will learn about the serious problems that can arise when primary care services fail during a disaster, along

with strategies to help them maintain access to care for patients and sustain a primary care practice in the face of an emergency situation.

Sponsored by the MMS and its Committee on Preparedness, in collaboration with the Massachusetts Department of Public Health, the program has been designated for 2.5 *AMA PRA Category 1 Credits*[™] and meets the Massachusetts Board of Registration in Medicine's criteria for risk management study.

Program details and registration information are available at www.massmed.org/cme/events/dpc2009. **VS**

Physician Focus Shines Light on Violence Prevention

February's *Physician Focus* local access TV program, co-produced by the MMS and HCAM-TV of Hopkinton, addresses partner violence. The program features (in photo, from left to right) guest Liza Sirota White, education manager for Jane Doe Inc., the Massachusetts Coalition Against Sexual Assault and Domestic Violence; host Barbara Herbert, M.D., chair of the MMS Committee on Violence Intervention and Prevention; and guest Elaine Alpert, M.D., editor of MMS's *Partner Violence: How to Recognize and Treat Victims of Abuse*, a comprehensive domestic violence curriculum for physicians and other health care providers.



Photo by Rick Gulla

"This problem affects the health of the survivor in more ways than injury," said Dr. Herbert. "It affects all aspects of health and may impact other family members or people in the community as well." Dr. Herbert recommends that physicians screen all patients for exposure to violence.

The prevention of violence, in all its forms, will be the subject of the fifth annual Public Health Leadership Forum, sponsored by the MMS and the Harvard School of Public Health, on April 29 at MMS headquarters in Waltham. **VS**

Chest Physicians Recommend Work History for Adult Asthma Patients

Physicians should ask all adults with asthma about possible workplace exposure to allergens, according to a recent publication by the American College of Chest Physicians (ACCP).

An ACCP-convened expert panel consisting of allergists, pulmonologists, and occupational medicine physicians reviewed evidence-based practice and issued a consensus statement in September 2008. That statement noted that about 15 percent of cases of adult asthma are attributable to occupational factors. The panel considered the substantial prevalence of work-related asthma as support for screening for work-related asthma in adults with new-onset or worsening asthma.

Further, the panel recommended follow-up, including investigations and consideration of similarly exposed coworkers. This proactive approach was applauded by Marcy Goldstein-Gelb of the Massachusetts Coalition for Occupational Safety and Health (MassCOSH), a nonprofit organization that promotes safe working conditions. "This consensus statement focuses on prevention," she noted. "Any individual with asthma will be seen as a warning that workplace conditions may be hazardous."

The panel emphasized confirming the asthma diagnosis, utilizing an occupational history to probe exposures, and exploring the relationship between asthma and work using serial measurements of peak flow, spirometry including methacholine responsiveness, and immunologic tests.

Testing Recommendations

William Beckett, M.D., M.P.H., a member of the ACCP panel and a Massachusetts internist/occupational medicine specialist, explained, "If a specific allergen is suspected as the cause of asthma — for example, wheat flour for a baker with new-onset asthma — serum IgE testing for wheat or skin-prick testing with wheat allergen can confirm sensitization." Dr. Beckett added that when treating a patient whose asthma might be due to workplace exposures, "the physician must decide whether it is safe for the

patient to return to work, and may also need to consider whether the workplace represents a hazard to others. If the asthma is occupational and a hazard is present, the patient needs written work restrictions and the employer should be notified of a hazard."

The panel's consensus statement also recognizes worsening of preexisting or concurrent asthma by workplace factors.

Working adults with new-onset or worsening asthma should be questioned about possible workplace triggers.

Adults with asthma due to sensitization may need to be removed from the workplace if the exposure cannot be eliminated. However, for individuals with work-exacerbated asthma, treatment

should be optimized and exposure to workplace triggers should be reduced.

The statement was published as a supplement to the September 2008 issue of *CHEST*, and can be downloaded at no charge by going to www.chestjournal.org/cgi/reprint/134/3_suppl/15.

The American College of Chest Physicians recommends physicians consider the following when a patient's asthma started or worsened during his or her working life:

- Do asthma symptoms differ during times away from work?
- Are symptoms of itching or burning eyes and runny nose worse at work?
- Did changes in work processes precede the onset of symptoms?
- Was there an unusual exposure in the 24 hours before the onset of initial asthma symptoms?

Suspected or confirmed cases of work-related asthma in Massachusetts must be reported to the Massachusetts Department of Public Health. Reporting forms are available at www.mass.gov/Eoehhs2/docs/dph/occupational_health/confidential_report_form.pdf. Physicians can suggest that their patients contact MassCOSH (www.masscosh.org/) for ideas on working with coworkers to improve conditions.

— Elise Pechter, M.P.H.
Occupational Health Surveillance Program
Massachusetts Department of Public Health

WEBSITE OF THE MONTH

Patient and Vaccine Safety during Power Outages

The severe start to this winter, with its resultant power outages, reminded us of the need to remain prepared. The Centers for Disease Control and Prevention emergency preparedness and response site has specific information about what to do in a power outage (www.bt.cdc.gov/disasters/poweroutage).

The "What You Need to Know When the Power Goes Out" page advises patients how to stay safe at home, work, and outside during a power outage, with information on how to avoid, recognize, and respond to hypothermia, carbon monoxide poisoning, and electric shock. The page also includes a link to information for health care providers about vaccine safety during a power outage.

STATE UPDATE

Prohibiting Tobacco Sales in Health Institutions: The Next Frontier in the “Tobacco Wars”

It is universally acknowledged that tobacco use is the single most preventable cause of premature death in the United States today. With more than 400,000 deaths annually attributed to smoking, tobacco kills more Americans than auto accidents, AIDS, alcohol and illegal drugs, and murders and suicides combined. Approximately 24 Massachusetts citizens die prematurely every day as a result of tobacco use.

Nonetheless, licensed health professionals can still be found providing care in locations — such as pharmacies — where tobacco products are sold. This is starting to change, and the MMS is helping lead the effort.

Last fall, the MMS testified before the Boston Public Health Commission in support of regulations to ban the sale of tobacco products at “health institutions” — any venue that provides health care services and employs licensed health care providers. That regulation was recently adopted and will take effect this month.

Boston’s regulation is similar to one already in force in San Francisco. While more municipalities may follow Boston’s and San Francisco’s lead, the MMS has taken the bold step of drafting legislation that would mirror Boston’s regulations and apply them to the entire state. The immediate impetus to file such legislation was the approval of a resolution at the recent Interim Meeting of the MMS House of Delegates that was sponsored by the Society’s officers. All indications are that the measure will win widespread support in the public health community.

The Massachusetts Medical Society is no newcomer to the “Tobacco Wars.” In addition to its long-standing efforts around tobacco control — ranging from support of prevention and treatment programs to clean air and tax initiatives — the Society has steadfastly held that the health professions have a special obligation to promote the public health whenever possible.

Some of us remember when smoking and the sale of tobacco products in hospitals were permitted, and even when physi-

cians appeared in cigarette advertisements. Fortunately, our hospitals, clinics, pharmacies and physicians’ offices are smoke-free today. One can no longer find a cigarette vending machine in a Massachusetts hospital, and increasingly facilities are making their grounds, in addition to their buildings, smoke-free as well.

Nonetheless, there is still work to be done. The use of tobacco products is antithetical to good health, and members of the public may find the acceptance of tobacco sales in health care facilities as an implicit justification of tobacco use.

The MMS believes that the use of tobacco products should be strongly discouraged by all health professionals and the institutions in which they work. This legislation — banning the sale of tobacco products by health care institutions and barring licensed health professionals from working in a professional capacity in locations where tobacco products are sold — would be an important next step in reducing illness and saving lives. **VS**

— Steve Shestakofsky

LEGISLATOR
OF THE MONTH

Senator Steven A. Baddour (D)

District: Amesbury, Haverhill, Merrimac, Methuen, Newburyport, North Andover (part), Salisbury

Committees: Transportation (Chair), Judiciary (Vice Chair), Senate Ways and Means, Municipalities and Regional Government, Senate Post Audit and Oversight



QUOTE: There is nothing more important in life than health. For years, I focused my attention on preventing disease in myself by eating well, exercising, and visiting my primary care physician regularly.

Once I became the father of two daughters, however, my attention shifted to keeping them healthy and happy. I began to look at the world differently and realized there was so much more we could be doing to keep our children safe from harm, especially in the area of preventable injuries.

During the last legislative session, I was extremely proud to sponsor our state’s new booster seat law, which requires all parents to use appropriate vehicle restraints on children through age 7, or until they’re 4 feet 9 inches tall, whichever comes first.

I am also committed to addressing the catastrophic pediatric injuries children can incur when riding on all-terrain vehicles (ATVs) by again pushing for new regulations that would prohibit children under the age of 14 from riding on any size ATV.

I look forward to working with the MMS on this and other common-sense measures to prevent pediatric injuries so that all our children can enjoy a healthy and joy-filled childhood.

FEDERAL UPDATE

2009 Agenda Links Economic Stimulus and Health Care Reform

With the nation and the world watching, President Barack Obama and the 111th Congress have an incredible opportunity — and a formidable challenge: to enact comprehensive health care reform. While the economy will unquestionably dominate the early days of the 111th Congress, a compelling case is being made that health care is a key economic issue.

Late in 2008, the presidential transition team worked to craft an economic stimulus package for consideration early in the year. As this issue of *Vital Signs* went to press, it appeared the President’s version will dedicate about one-fifth of the proposed \$800 billion stimulus package to health care. Early reports suggest that \$100 billion would go to help states with growing and underfunded Medicaid programs. The President has also advocated strenuously for funding to help physicians purchase health information technology.

In late December, the Congressional Budget Office (CBO) released a cost-benefit analysis of 15 health care reform options. While the general finding was that most of the options would place signifi-

cant cost burdens on the government, the CBO predicted that fostering the use of health information technology (including electronic medical records) would save the federal government \$7 billion over the first 5 years and nearly \$35 billion over 10 years, primarily through reductions in medical errors, lower health insurance premiums, and by avoiding unnecessary tests and procedures.

Another health reform option predicted to positively impact the budget if enacted is a requirement (similar to that in the Massachusetts Health Reform Law) that all but the smallest employers who fail to provide health insurance to their employees pay a fee. The CBO estimates that this would result in \$47 billion in new revenues.

The Massachusetts law continues to serve as a possible framework for national health care reform. Both the Senate Finance Committee’s proposal and President Obama’s stated health care positions (see *Vital Signs*, December 2008/January 2009, page 1) support an “incremental universalism” approach that includes

Massachusetts-style elements such as “play or pay” provisions for employers, expansions of Medicaid eligibility and other public programs, and some form of “connector” to help people purchase more affordable health insurance.

Sen. Edward Kennedy continues to lead efforts in the Senate to develop a comprehensive proposal that would work at the national level. Sen. Kennedy recognizes that while the principles of the Massachusetts plan are applicable nationally, there are significant differences between the state and national markets.

This year considerable attention will also focus on efforts to change the Medicare physician payment formula. While a solution is far from clear, there is no question that Congress wants to move away from using volume as a basis for physician payment and toward a still-undefined measurement of value and cost effectiveness. The MMS continues to work with the Massachusetts Congressional delegation and the AMA to forge meaningful national health care reform. **VS**

— Alex. Calcagno

MMS Legislative Workshop

Tuesday, February 10, 7 to 9 p.m.

Massachusetts General Hospital's Ether Dome, Boston

This event will provide excellent preparation for anyone interested in getting involved in future MMS legislative advocacy initiatives, or for anyone planning to attend the AMA Lobby Day and/or National Advocacy Conference in Washington, D.C.

Dinner will be provided, and parking will be validated for the first 20 registrants.

Sponsored by the MMS and its Committee on Young Physicians and the Resident and Fellow Section

RSVP by Tuesday, February 3, to lpollard@mms.org or (781) 434-7315.

PIAM Teams with Cardinal Health to Launch New Purchasing Program

PIAM has partnered with Cardinal Health to offer MMS members direct-purchasing access to medical/surgical supplies; resources to analyze and improve practice profitability; and guidance on new-office setup, design, and cost savings.

Founded in 1970, Cardinal Health provides products and services that help hospitals, physician offices, and pharmacies reduce costs and improve safety, productivity, and profitability.

MMS members will be able to order supplies from industry-leading manufacturers such as Quidel, Midmark, Welch Allyn, Siemens, Inverness, Roche, and other well-known companies. Available merchandise includes capital equipment, diagnostic tests, bandages and sutures, pharmaceuticals, and lab products.

In addition, PIAM has arranged for Cardinal Health to provide Society members with members-only promotions and discounts each month. If you would like to be notified about these monthly promotions, go to www.cardinalhealth.com/piam, and click on the "Send Me Email Updates" button on the right side of the page.

MMS members or their practice administrators who open an account with Cardinal Health during February or March will receive a welcome package of medical supplies worth \$100. To open an account, go to www.cardinalhealth.com/piam and click on "New Account Promo," or contact Leo Proppe Jr. at Cardinal Health at (800) 456-1894, ext. 7716. **VS**

Russian Medical Delegation Visits MMS



On December 16, 2008, 24 physicians and medical managers from the Regional Association of Managers in Medical Services, based in St. Petersburg, Russia, took part in an overview of America's health care system, presented by MMS President Bruce Auerbach, M.D., and MMS staff. The visit was in collaboration with the Heller School for Social Policy and Management at Brandeis University. MMS staff presented information on health care financing, physician education and licensing, and the role of politics in health care reform. The Heller School hopes to repeat this event in 2009.

PHYSICIAN HEALTH MATTERS

Guidelines for Pain Management in Physician-Patients

Because of their knowledge of opioid analgesics and their unique access to such medications, physicians may be at greater risk for abusing prescription painkillers than those with less access. This risk notwithstanding, physicians are also patients who have a right to expect adequate treatment if they experience acute or chronic pain.

The 1992 Physician Substance Use Survey (PSUS) polled 9,600 physicians about their own use of psychoactive substances. The PSUS found that 8 percent of physician respondents had a lifetime occurrence of a substance use disorder, but because the PSUS relied on physician self-reporting, it may have underestimated actual rates of physician substance use.

The PSUS and other studies have found that anesthesiologists and emergency medicine physicians are at greater risk than other physicians for developing substance use disorders. The PSUS also found that physicians were more likely than non-physicians to misuse prescription analgesics and tranquilizers, but less likely than non-physicians to use illicit drugs.

A large proportion of physicians who reported misusing prescription drugs in the PSUS did so for reasons of "self treatment." Self-treatment may thus represent an occupational hazard for physicians.

Because of this risk of misuse, we strongly discourage physicians from self-prescribing *any* medications, and we remind physicians that it is a violation of Massachusetts law to self-prescribe opioids, benzodiazepines, and other medications in Schedules II-IV.

Physicians at risk for abusing substances may also obtain opioids and other medications from a colleague, who may be more likely to prescribe liberally — and less likely to implement ordinary safeguards against misuse — for another physician.

For physicians who develop either acute or chronic pain, short- or long-term treatment with opioids may be indicated. When this is the case, we recommend the following procedures to reduce the risk of misuse:

- Select one treating physician, ideally your primary care provider, to be in charge of all prescriptions. Ask this physician if it is safe for you to continue practicing medicine while taking

narcotic analgesics, especially during the early phase of treatment.

- Fill all prescriptions at one pharmacy.
- Work with your primary care provider to develop a comprehensive plan for pain management that maximizes the use of non-opioid treatments such as NSAIDs, acetaminophen, and physical therapy.
- Allow open communication among all treating physicians, and always consult with a pain management specialist in cases of chronic, non-malignant pain.
- Have your primary care physician occasionally order urine for toxicology, to document that you are taking the opioid as prescribed, and not taking any non-prescribed medications or illicit drugs.
- If you have a history of substance abuse or dependence, consult with an addiction physician or specialist with expertise in this area, and allow open communication between that provider and all other treating clinicians.

Common warning signs of opioid misuse include a physician who is seeing multiple providers and receiving multiple prescriptions from them and a physician who self-prescribes, asks colleagues who are not treating him to write prescriptions as "a favor," or asks staff members to fill prescriptions on his or her behalf. Other possible signs include personality changes, bizarre or erratic behaviors, unexplained absences, excessive ordering of drug supplies, prolonged lunch breaks, excessive daytime naps, or significant physical changes.

What should you do if you think you or someone you know is abusing opioids or has developed a problem with prescription drugs? Given the high stakes — the individual physician's health, the well-being of the physician's patients, and the potential impact on the physician's career — we recommend prompt intervention and referral to Physician Health Services (PHS). PHS has internal resources for evaluating these concerns, and PHS physicians can also make referrals for more complete evaluations and/or treatment when indicated. PHS can be reached at (781) 434-7404. **VS**

— J. Wesley Boyd, M.D., Ph.D., and
John Knight, M.D.
PHS Associate Directors

ACROSS THE COMMONWEALTH

District News and Events

Berkshire — Family Social Event. Sat., Feb. 28, 6 p.m. registration, 7 p.m. show. Mad Science, Colonial Theatre, Pittsfield. For more information, contact the West Central Regional Office.

Essex South — Delegates Meeting. Thurs., Feb. 26, 6 p.m. Location: Hawthorne Hotel, Salem. For more information, contact the Northeast Regional Office.

Franklin — Executive Committee Meeting. Fri., Feb. 20, 7:30 a.m. Location: Baystate Franklin Medical Center, Greenfield. For more information, contact the West Central Regional Office.

Hampden — Legislative Breakfast. Fri., March 27, 7:30 to 9 a.m. Location: Clarion Banquet and Conference Center, West Springfield. Please contact Suzanne Skibinski with any comments/questions to be submitted to legislators. For more information, contact Suzanne Skibinski at (413) 736-0661 or hdms@massmed.org.

Middlesex North — District Meeting. Wed., Feb. 4, 6 p.m. Location: Vesper Country Club, Tyngsboro. Speaker: Bruce S. Auerbach, M.D., MMS president. For more information, contact the Northeast Regional Office.

Norfolk South — Executive Committee Meeting. Tues., Feb. 10, 6:30 p.m. Location: Peppercornz on Main, South Weymouth. For more information, contact the Southeast Regional Office.

Suffolk — Winter Reception. Thurs., Feb. 19, 6 p.m. Location: Clery's Restaurant, Boston. For more information, contact the Northeast Regional Office.

Worcester — 213th Annual Oration. Wed., Feb. 11, 5:30 p.m. Location: Beechwood Hotel, Worcester. "Monitoring Competence and Enhancing Performance: Effective Ways to Support the Practicing Physician." Orator: Richard Aghababian, M.D., associate dean for continuing medical education, UMass. For more information, contact Joyce Cariglia at (508) 753-1579.

Worcester North — Executive Committee Meeting. Tues., Feb. 17, 6 p.m. For more information, contact the West Central Regional Office.

Statewide News and Events

Arts, History, Humanism, and Culture Member Interest Network — Executive Committee Meeting. Wed., Feb 25, 6 p.m. Location: Mechanics Hall, Worcester. For more information, contact the West Central Regional Office.

If you have news for Across the Commonwealth, contact Florence Keefe, Northeast Regional Office, at (800) 944-5562 or fkeefe@mms.org; Linda Howard, Southeast Regional Office, at (800) 322-3301 or lhoward@mms.org; or Cathy Salas, West Central Regional Office, at (800) 522-3112 or csalas@mms.org.

In Memoriam

The following deaths of MMS members were reported to the Society in December 2008 and January 2009. We also note member deaths on the MMS website at www.massmed.org/memoriam.

Joseph F. Arico, M.D., 87; Brewster, MA; Boston University School of Medicine, 1945; died November 28, 2008. **Patrick M. Cooke, M.D.**, 55; West Stafford, CT; Howard University College of Medicine, 1984; died November 27, 2008. **Chester C. d'Autremont, M.D.**, 88; Lincoln, MA; Harvard Medical School, 1944; died December 6, 2008. **Charles W. Fairfax II, M.D.**, 77; Dartmouth, MA; Harvard Medical School, 1957; died December 9, 2008. **Adolph F. Friedman, M.D.**, 91; Norwell, MA; University of Vermont College of Medicine, 1953; died November 21, 2008. **John R. Gehring, M.D.**, 81; Newton, MA; Harvard Medical School, 1953; died December 23, 2008. **Earl P. Gelman, M.D.**, 72; Northbrook, IL; Chicago Medical School, 1960; died September 24, 2007. **Nathaniel Gould, M.D.**, 95; Birmingham, AL; University of Vermont College of Medicine, 1937; died November 1, 2008. **Alan D. Hilgenberg, M.D.**, 64; Boston, MA; University of Michigan Medical School, 1969; died December 25, 2008. **Julian G. Snyder, M.D.**, 81; Waban, MA; Tufts University School of Medicine, 1955; died August 2, 2008.

2009 Research Poster Symposium

The MMS Resident and Fellow and Medical Student Sections will host their fourth Research Poster Symposium on Saturday, April 25, at MMS headquarters in Waltham.

The symposium offers residents, fellows, and medical students the opportunity to display their research, meet other members, and discover what their peers are working on.

Presenters compete in one of four categories: basic research, clinical research, clinical vignettes, and health policy/medical education.

Three individuals in each category will be awarded cash prizes — \$150 for first place, \$100 for second, and \$50 for third. Letters of recognition from the MMS president will be sent to the top winners' medical school deans or resident program directors. First-prize posters will be displayed at the MMS Annual Meeting in May.

Submission Guidelines

- Deadline for abstract submission: March 16

- Abstracts should be a maximum of 400 words, submitted in a Microsoft Word document with one-inch margins in 12-point Times New Roman font.
- Abstract should include introduction, methods, results, and discussion.
- All research must be original work, not published previously in any copyrighted publication. Work previously presented at another poster symposium or similar event will be accepted.
- Primary author must be a resident/fellow/medical student member of the MMS.
- Primary authors must be able to attend the symposium on April 25 to present their work.
- One primary author may submit a maximum of two abstracts. **VS**

E-mail questions or abstract submissions to Lindsay Pollard at lpollard@mms.org.

MMS Committee Appointments

Deadline for Consideration: March 6

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

Committee appointments are usually for three-year renewable commitments. For those with limited time, we have resources for distance participation, including conference calls, online meetings, and videoconferencing.

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

Committees Appointed by the Board of Trustees (limited openings in accordance with bylaws)

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

Standing Committees Appointed by the President-Elect (limited openings in accordance with bylaws)

- Bylaws
- Communications
- Ethics,

- Grievances, and Professional Standards
- Interspecialty
- Judicial
- Medical Education
- Membership
- Public Health
- Publications
- Quality of Medical Practice

Special Committees Appointed by the President-Elect

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

District-Appointed Committees

- Legislation
- Nominations

Member Interest Network (MIN) Executive Council

- Arts, History, Humanism and Culture **VS**



MASSACHUSETTS MEDICAL SOCIETY

EVERY PHYSICIAN MATTERS, EACH PATIENT COUNTS.

WHAT'S ON THE WEB?

► Renew Your Dues Online

Login to the secure MMS website and use your credit card.
www.massmed.org/renew

► MMS Physician Focus on the Web

Health information cable TV program, updated monthly. Share this web address with your patients. www.massmed.org/physicianfocus

► Defensive Medicine Study

Groundbreaking MMS study on the cost of defensive medicine to the state's health care system
www.massmed.org/defensivemedicine

WWW.MASSMED.ORG

Gift Regulations

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practitioner," said the DPH's Lopes. "We should shine a light and let patients see what kind of interactions their doctors have in prescribing medication, but at the same time we don't want to inhibit legitimate research or education."

Despite the DPH's search for a middle ground, Health Care for All, the statewide advocacy group, says the proposed regulations don't go far enough. "We endorse a complete ban on gifts," said Amy Whitcomb Slemmer, the organization's executive director. "We feel strongly that no harm will be done and that it will be better for consumers if there are no gifts."

Slemmer went on to say that the DPH has "worked very hard to give us a work in progress, but our position is that there are billions of dollars spent each year by both industries giving gifts and trinkets to doctors, and that these expenses are ultimately passed on to consumers."

Evidence Suggests Regulation Needed

According to the DPH, there is evidence of the need for regulation. A 2000 study in the *Journal of the American Medical Association* found that physician-industry interactions are associated with "nonrational prescribing" and other behaviors that may not serve the best interests of pa-

tients. The Prescription Project, an advocacy group, maintains that even small gifts may create an unconscious "demand for reciprocity."

The American Medical Association's guidelines, which form the basis for MMS policy, state that any gifts accepted by physicians should be related to patient benefit and must be modest in nature. In addition, PhRMA, AdvaMed, and the federal Office of the Inspector General have all adopted voluntary, nonbinding policy guidelines regarding gifts to physicians.

However, the DPH says that its proposed regulations would make Massachusetts the only state with a statewide code of conduct, compliance and disclosure requirements, public reporting, and regulation of the device industry as well as drug makers.

The DPH's Lopes said the program will increase the quality of health care services by giving consumers more information about caregivers, while also helping curb costs by reducing manufacturers' marketing and advertising outlays.

Dire Consequences Foreseen

Drug manufacturers, meanwhile, warn of serious medical- and economic-development consequences should the draft regulations hold. "Physicians and other health care providers who do not want such personal information disclosed may

decide to no longer work with pharmaceutical research companies sponsoring clinical trials, which could hold up the development of important new medicines for patients," PhRMA's Johnson said when the law was passed last August.

Despite plenty of pushback from various interest groups, Lopes doesn't foresee wholesale changes coming out of the hearing process. She hopes a final set of regulations will be ready for approval by the Public Health Council in March. The law to which the regulations apply takes effect July 1. **VS**

Medical Blogs

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Let's Talk Health Care. Author: Charles Baker, president of Harvard Pilgrim Health Care. Baker's blog illuminates the health plans' approach to various health policy conundrums. Updated once or twice a month. letstalkhealthcare.org

Life as a Healthcare CIO. Author: John Halamka, M.D., CIO of CareGroup. Commentary on the convergence of health care and IT. Updated almost daily. geekdoctor.blogspot.com

Kevin MD. Author: Kevin Pho, M.D. This iconoclastic internist from Nashua, N.H., is the most influential and most widely cited individual physician blogger in America today. Updated daily. kevinmd.com **VS**

MMS Sponsored & Jointly Sponsored CME Activities

To register for any of these activities, call (800) 843-6356.

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

Live CME Activities

Go to www.massmed.org/cme/events.

4th Annual Women's Cardiac Health Conference: Heart Healthy Strategies to Empower Your Patients
February 6, 8:30 a.m.–3:15 p.m.
MMS headquarters, Waltham.
Sponsored by the MMS and its Committee on Women in Medicine, in collaboration with the American Heart Association and the Institute of Lifestyle Medicine. 5.5 Credits (3.25 RM)

Chronic Disease Management: Critical to the Quality and Cost Equation
March 6, 8:30 a.m.–12:30 p.m.
MMS headquarters, Waltham.
Sponsored by the MMS and the *New England Journal of Medicine*. 4.25 Credits (RM)

Disaster and Primary Care: How to Protect Your Patients and Your Practice

March 31, 6:30–9:00 p.m. MMS headquarters, Waltham. Sponsored by the MMS in collaboration with the Massachusetts Department of Public Health. 2.5 Credits (RM)

Online CME Activities

Go to www.massmed.org/cme.

Massachusetts Medical Law Report
Quarterly Risk Management CME Series

NEW 'Minute Clinics' Raise Round-the-Clock Risks
1.0 Credit (RM)

NEW E-Prescribing Regulations Applauded by Doctors, Lawyers
1.0 Credit (RM)

NEW How to E-mail Patients without Worrying about Liability
1.0 Credit (RM)

Reducing Errors in Patient Handoffs

1.0 Credit (RM)

Dealing with Difficult Patients

1.0 Credit (RM)

A New Kind of Bedside Manner: The Rise of Apology Policies

1.0 Credit (RM)

Preparedness Risk Management CME Series

Pandemic Flu: Practical Information and Strategies for Preparedness
2.0 Credits (RM)

Know the Response: Disaster Management and Communication for the Health Care Provider
3.0 Credits (RM)

More E-Prescribing Courses:

Electronic Prescribing Education
2.5 Credits (RM)

National E-Prescribing Conference (15 courses) 1 or 2 Credits each

Save the Dates

March 12
E-Prescribing Conference

April 29
5th Annual Public Health Leadership Forum

May 7
Ethics Forum: Racial and Ethnic Disparities in Care

May 9
2009 Annual Education Program: To Age or Not to Age

2009 Shattuck Lecture: The Hypertension Paradox

CME CREDIT: Unless otherwise noted, each activity is designated for AMA PRA Category 1 Credits™. RM indicates that the activity or a portion thereof meets the Massachusetts Board of Registration in Medicine criteria for risk management study. CME ACCREDITATION: The Massachusetts Medical Society is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.