

VITAL SIGNS

VOLUME 18, ISSUE 5, MAY 2013



Every physician matters,
each patient counts.



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Choosing Wisely Campaign Educates Physicians, Patients on Wasteful Care

Reeducating Patients with Support from Medical Specialty Societies

BY VICKI RITTERBAND

The grandmother was insistent. She wanted antibiotics. Her 7-month-old grandson was terribly congested and his mucus was green. In her child-rearing days, that meant the doctor gave you antibiotics.

John O'Reilly, M.D., explained the reasons behind his reluctance, showed her and the mother how to use a nasal bulb syringe to clear the baby's stuffy nose, and sent them home — without a prescription, but with clear instructions about developments that would prompt a follow-up visit.

"It becomes a negotiation and an opportunity to do some teaching," said Dr. O'Reilly, a pediatrician with Baystate

Pediatric Associates, part of Baystate Children's Hospital, and president of the Massachusetts Chapter of the American Academy of Pediatrics. "And I always try to bring it back to what's the best thing for the kid."

The Lists

Choosing Wisely, an initiative of the American Board of Internal Medicine (ABIM) Foundation, seeks to encourage conversations like this one in medical offices across the country. It urges specialty societies to create their own lists of tests and procedures that are sometimes unnecessary and can do harm. So far, 25 societies have submitted their lists. By the end of the year, an additional 15

will have done the same, representing nearly every major allopathic specialty, according to Daniel Wolfson, ABIM Foundation's executive vice president and chief operating officer.

For pediatricians like Dr. O'Reilly, the antibiotic admonition is number one on their list. Neurologists are warned, among other things, about performing imaging of the carotid arteries for simple syncope. Performing radionuclide imaging as part of routine follow-up in asymptomatic patients is the third no-no on the American Society of Nuclear Cardiology (ASNC) list. As part of the Choosing Wisely campaign, the MMS, in partnership with

the ASNC and in collaboration with the Massachusetts Chapter of the American College of Cardiology (ACC), is participating in a \$50,000 grant project from the ABIM Foundation to study and educate physicians and patients about the overuse of nuclear cardiology tests and to come up with some solutions.

Most, if not all, professional societies already have clinical guidelines, but what makes Choosing Wisely so powerful is that societies are coming together in large numbers and developing lists across specialties, according to Michael Barry, M.D., president of the Informed Medical Decisions Foundation and medical director of

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'Here is Where Policy, Research, and Clinical Practice Meet'

Vital Signs Speaks with Ann Hwang, M.D.

BY WILLIAM RYDER

A physician working in state government is an unconventional pairing, but Ann Hwang, M.D., says it has been an exciting professional challenge.

"I feel that being a physician in Massachusetts is a lot like being an artist in New York — there is such a sense of community, innovation, and vibrancy. Here is where policy, research, and clinical practice meet," said Dr. Hwang, director of health care policy and strategy for the

Massachusetts Executive Office of Health and Human Services (EOHHS).



Ann Hwang, M.D.

Her position within the Patrick-Murray administration falls under the leadership of EOHHS Secretary John Polanowicz, former president of St. Elizabeth's Medical Center. She is charged with overseeing a wide variety of regulatory issues and implementing the many payment and access reforms signed into law in Massachusetts and federally.

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Eight Principles of Patient Engagement

BY TALIA GOLDSMITH

Today, physicians not only have to change the way they interpret and use clinical data to improve overall patient care, but they also have to find ways to "engage" patients.

Patient portals, email, and patient education material are only a few of the many tools that are used to engage patients in their health care. Recent studies suggest that patient engagement can lead to better health outcomes, contribute to improvements in quality and patient safety, and help control health care costs. This area is considered so important that in 2008 the National Quality Forum declared patient and family engagement to be one

of six national priorities to eradicate disparities, reduce harm, and remove waste from the health care system.

On March 1, the MMS hosted a program, "The Impact of Effective Communication on Patients, Colleagues, and Metrics," which featured three expert speakers on the topic. Dr. Ronald M. Epstein, Dr. Helen Riess, and Dr. David L. Longworth addressed the key areas of patient engagement, care coordination, physician-to-patient communication, and physician-to-physician communication.

Dr. Longworth, who practices at the Cleveland Clinic, uses a

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PRESIDENT'S MESSAGE



Reflections on Mentors and Advocacy

As my presidency draws to a close, I wanted to reflect on the importance of two issues that are deeply meaningful to me: advocacy and mentoring.

In my first *President's Message*, I wrote that as physicians, "we can learn the true art of medicine from each other."

After a year in this position, I believe this even more strongly. The MMS is thriving with members who support each other's learning and growth.

I look to two of the mentors who made a difference in my own career — Dr. Leonard Morse and Dr. Ronald Arky. By example, they taught generations of physicians how to maintain the highest ethical standards. They continue a tradition of passing down knowledge from doctor to doctor that dates back over 4,500 years.

I hope the MMS will continue to foster opportunities for members to form new mentoring relationships and foster existing ones.

When physicians have the support and guidance of our peers, we are stronger advocates for our profession and our patients.

We were called upon repeatedly this year to demonstrate public leadership on difficult issues such as physician-assisted suicide, medical marijuana, health payment reform, and anti-opioid abuse efforts.

Our patients trusted us to lead them on these issues because they know we will stand for them and with them throughout their lives until the very end.

It has been an honor serving as your president.

Thank you,

Richard V. Aghababian

— Richard V. Aghababian, M.D.

Choosing Wisely

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the John D. Stoeckle Center for Primary Care Innovation at Massachusetts General Hospital. "That should get greater notice among physicians and patients," Dr. Barry said. "It's not a collection of isolated efforts, but rather a joint declaration that issues of cost and harm are really important and we're going to organize our efforts."

The amount of waste in the health care system is concerning. An estimated 30 percent of health care spending in 2009 — approximately \$750 billion — was spent on unnecessary services, excessive administrative costs, fraud, and other problems, according to the Institute of Medicine's (IOM) 2012 report, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*.

From Policy to Practice

To succeed, the Choosing Wisely campaign must make the jump from policy to practice. To that end, it will be giving physicians the tools to have those sometimes difficult conversations with patients — through education modules that model how to explain and reassure patients that forgoing a specific test or procedure is the right thing to do. The ABIM Foundation has also partnered with *Consumer Reports* to create fact sheets for patients that explain, for example, when they need bone density tests, colonoscopies, and imaging stress tests and when they don't.

"This takes a lot of re-education of the patient and a lot of support from the doctors," said Laura Zucker, M.D., a family practice physician with Family Practice Group in Arlington. "People have

acute back pain. They want to know exactly what's going on so they're often angling for an MRI. It takes a lot of time to have that conversation — that the majority of people get better no matter what they do. And it takes a lot of support on my part."

The MMS and the ASNC will develop a website to educate patients about nuclear cardiac imaging and radiation optimization. The partners will also develop two webinars — one for referring physicians and one for physicians who perform cardiac imaging — that focus on the appropriate use of the technology. Physicians will

also be able to track their rate of appropriate and inappropriate cardiac nuclear testing referrals by sending data to a web-based registry. Physicians who report will be eligible for bonuses under Medicare's Physician Quality Reporting System.

"The MMS welcomes the opportunity to explore ways to improve quality, accountability, and cost-effectiveness in health care," said Elaine Kirshenbaum, MMS vice president for Policy, Planning, and Member Services, and the society's lead on the collaboration. "We all want to do what's right." **VS**

A Sampling of Specialty Lists

Don't order sinus computed tomography (CT) or indiscriminately prescribe antibiotics for uncomplicated acute rhinosinusitis.

— American Academy of Allergy, Asthma, and Immunology

Don't recommend percutaneous feeding tubes in patients with advanced dementia; instead, offer oral assisted feeding.

— American Academy of Hospice and Palliative Medicine and American Geriatrics Society

Don't place, or leave in place, urinary catheters for incontinence or convenience or monitoring of output for non-critically ill patients (acceptable indications: critical illness, obstruction, hospice, peri-operatively for <2 days for urologic procedures; use weights instead to monitor diuresis).

— Society of Hospital Medicine—Adult Hospital Medicine

Don't obtain screening exercise electrocardiogram testing in individuals who are asymptomatic and at low risk for coronary heart disease.

— American College of Physicians

Don't order antibiotics for adenoviral conjunctivitis (pink eye). — American Academy of Ophthalmology

Don't prescribe testosterone to men with erectile dysfunction who have normal testosterone levels.

— American Urological Association

Don't do work up for clotting disorder (order hypercoagulable testing) for patients who develop their first episode of deep vein thrombosis (DVT) in the setting of a known cause.

— Society for Vascular Medicine

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Patient-Centered Medical Home: More than the Newest Buzzword in Health Care

Accountable care organization. Integrated delivery system. Alternative quality contract. Global budget. All of these are buzzwords that have been floating through the health care industry since the enactment of the Affordable Care Act.

More recently, the term patient-centered medical home (PCMH) has captured the spotlight, but what does it really mean and how does it differ from other health care reform-related terms? Furthermore, what do doctors in Massachusetts need to know about it?

The PCMH movement has been gathering momentum in Massachusetts and throughout the nation. In Massachusetts alone, there are more than 46 medical homes participating in the official Medicaid PCMH initiative. This is a model of care that centers around the patient. The patient works with a primary care provider who, along with a cross-functional care team, collectively cares for the patient and coordinates with other qualified providers as needed.

A key element that supports this concept is health care information technology and systems (including registries and information exchanges). The PCMH model has five core attributes:

- **Comprehensive care:** The PCMH is responsible for meeting a patient's physical and mental health needs throughout the care continuum. In order to achieve the goal of providing ongoing comprehensive care, the care team may work closely with a number of different physicians, advanced practice nurses, physician assistants, nurses, pharmacists, social workers, educators, and care coordinators in the community. Depending on the size of the practice, virtual teams may be formed to link with patients and providers.
- **Patient-centered:** In a medical home setting, the physician and care team partner with the patient to understand the



patient's specific needs, culture, values, and preferences and factor these into the decision-making

process. Patients are actively engaged in learning how to manage their own care to the extent they choose to be involved. Furthermore, this model recognizes the importance of including family in the conversation, ensuring that all involved parties are fully informed.

- **Coordinated care:** Care coordination is an important function of the medical home model. This means that the medical home coordinates with all appropriate entities across the broader health care system, including specialty care, hospitals, home health care, and community services. Maintaining open lines of communication and transparency facilitates this process and ensures a smooth transition, particularly when patients are discharged from the hospital.

- **Accessible services:** The PCMH ensures access to patients by shortening wait times for urgent needs and enhancing office hours. During off hours, a member of the care team may be reached by telephone or by other communication methods, such as email, so that there is no gap in coverage.
- **Quality and safety:** Commitment in ongoing initiatives that support quality and safety are important in the medical home model. This may include using evidence-based medicine and other clinical decision support tools to help guide the patient care process. Engaging in performance measurement and measuring patient satisfaction are also important functions that will help drive quality improvement efforts.

For more information on how to become a certified PCMH, visit www.massmed.org/pprc, or call the Physician Practice Resource Center at (781) 434-7702. **VS**

— Talia Goldsmith

Eight Principles of Patient Engagement

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"wellness widget," an internal tool to create personalized patient assessments of multiple wellness domains with customized intervention and treatment recommendations. This is used as part of the pre-visit planning work flow and is overlaid on EHRs. Wellness domains covered in the widget include tobacco use, nutrition, exercise, sleep hygiene, and depression screening. Another tactic that may be used to improve patient engagement is the "4 Habits Model." This model was utilized to train thousands of providers in the Kaiser Permanente system and combines evaluative and descriptive elements of physician communication. The

Cleveland Clinic adopted it as a component of their patient engagement and patient experience strategies. The four habits are: invest in the beginning; elicit the patient's perspective; demonstrate empathy; and invest in the end.

Dr. Epstein, professor of family medicine, psychiatry, oncology, and nursing at the University of Rochester Medical Center, talked about the importance of doctor-to-doctor communication. He stressed that poor communication may lead to errors and lapses in care. Furthermore, he explained that while EHRs should ideally facilitate the communication process, they often have the opposite effect. Dr. Epstein stressed that today's challenges in communication are ever growing

due to an increasing geographic isolation of clinicians, poorly defined roles and responsibilities, multiple communication media options that exist, and lack of reimbursement for communication. In order to address the many challenges that exist in today's environment, Dr. Epstein suggested using the following eight principles in practice:

1. **Put patients first:** Do the right thing and keep them informed.
2. **Know your colleague(s):** Create respectful working partnerships.
3. **Consider the medium:** Use face-to-face, page, or phone for sensitive or urgent issues.

4. **Say the important things first:** Have specific reasons and goals for consultation and use clear, succinct recommendations.
5. **Be transparent — let them know what you're thinking:** Judgment, values, uncertainties, and "intangibles."
6. **Actively consider other viewpoints.**
7. **Don't be afraid to disagree (respectfully).**
8. **Be explicit about follow-up plans and roles.**

For more information on patient engagement and to view the program online, visit www.massmed.org/pprc. **VS**

Commission to End Health Care Disparities Meets

Members of the national Commission to End Health Care Disparities (CEHCD) recently met for a two-day conference to discuss progress toward eliminating health care disparities. The meeting featured presentations on programs addressing cardiovascular disease disparities, as well as presentations from working groups on advocacy and policy, health professional awareness, education and training, research and data resources, workforce diversity, and leadership development.

Disparities in care exist across a wide variety of illnesses, including cardiovascular disease, asthma, diabetes, flu, infant mortality, cancer, HIV/AIDS, viral hepatitis,



Photo by Robyn Alie

Physicians playing a doctor and patient in a Doctors Back to School skit at a Denver-area school during the Commission to End Health Care Disparities meeting. Doctors Back to School aims to inspire students of diverse racial and ethnic backgrounds to consider a career in medicine.

chronic liver diseases and cirrhosis, kidney disease, injury deaths,

violence, behavioral health, and oral health.

CEHCD was established in 2004 by the AMA in response to a 2003 Institute of Medicine report that found the existence of unacceptable racial and ethnic disparities in health care, which in many cases were associated with worse outcomes for patients.

That report found that “many sources — including health systems, health care providers, patients, and utilization managers — may contribute to racial and ethnic disparities in health care,” and that “bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers

may contribute to racial and ethnic disparities in health care.”

The commission consists of more than 70 national and state medical and health professional societies, including the MMS, which work collaboratively to promote action to eliminate disparities in health care and strengthen the health care system by increasing awareness among physicians and health professionals and advocating for action, including by the federal government.

For more information about the commission and resources related to health care disparities, visit www.massmed.org/diversity. **VS**

— Robyn Alie

Mass. Medical Marijuana Regulations to Be Finalized Soon

On March 29, the state Department of Public Health released proposed regulations for certification, dispensing, and use of medical marijuana.

The proposed regulations, which the DPH is scheduled to finalize later this spring, allow registered patients to receive up to a 60-day supply — about 10 ounces of marijuana in leaf form.

Patients seeking medical marijuana must currently have a debilitating medical condition and be diagnosed with cancer, glaucoma, HIV/AIDS, hepatitis C, ALS, Crohn's disease, Parkinson's disease, multiple sclerosis, or other conditions as determined by a physician, and must obtain registration cards from the DPH that are valid for five years.

Patients under 18 years of age with a “life-limiting” illness may use medical marijuana if they have parental consent and certification by two physicians.

Physicians who certify patients for medical marijuana must:

- Have a “bona-fide physician-patient relationship,” which has been defined as: “A relationship between a certifying physician, acting in the usual course of his or her professional practice, and a patient in which the physician has conducted a clinical visit, completed and documented a

full assessment of the patient's medical history and current medical condition, has explained the potential benefits and risks of marijuana use, and has a role in the ongoing care and treatment of the patient.”

- Have a full active license, with at least one established place of business in Massachusetts
- Complete two hours of CME credits on the proper use of medical marijuana, beginning January 2014
- Utilize the state Prescription Monitoring Program before certifying a patient

Physicians must NOT:

- Have a financial relationship with a marijuana dispensary nor may their co-workers or family members
- Certify marijuana use for themselves
- Delegate certification to another

The state will oversee the program, but local authorities may pass zoning regulations or impose local fees and other regulations that do not conflict with state law.

To view the full regulations and MMS's response, visit www.massmed.org/marijuana.

Getting Men Healthier — A Physician's Playbook June 12 at MMS Headquarters

When it comes to health and longevity, men lag considerably behind women. On average white men die five years younger than white women, and black men die 13 years younger than black women. Men are twice as likely as women to die of heart disease and liver disease and four times as likely to die of suicide or homicide.

At the same time, men are often out of touch with the health care system. Almost 19 percent of all men under the age of 65 do not have health insurance, according to the Centers for Disease Control and Prevention. Compared to women, men are 24 percent less likely to have visited the doctor in the past year and are 30 percent more likely to be hospitalized for preventable conditions such as congestive heart failure and complications from diabetes, according to the Agency for Healthcare Research and Quality.

On June 12, from 8:00 a.m. to 5:00 p.m., the MMS Committee on Men's Health will sponsor *Getting Men Healthier — A Physician's Playbook*, a CME event designed to help physicians better help their male patients.

Some topics to be covered include:

- *The Play of Chance: The Rise of Medical Evidence*, Jeffrey Drazen, M.D., editor-in-chief, *New England Journal of Medicine*
- *The PSA Controversy*, Alan Edelman, M.D., hematologist/oncologist, Winchester Medical Associates; Peter Tiffany, M.D., urologic oncologist, Mystic Valley Urology; Adam Feldman, M.D., M.P.H., urologic oncologist, Massachusetts General Hospital
- *When Doctors Don't Listen*, Joshua Kosowsky, M.D., clinical director of the Emergency Department, Brigham and Women's Hospital, and co-author of *When Doctors Don't Listen: How to Avoid Misdiagnoses and Unnecessary Tests*
- *What are the REAL Complications of Bariatric Surgery?*, Dmitry Nepomnayshy M.D., associate professor of surgery, Tufts University School of Medicine

To register, visit www.massmed.org/MH2013, or call (800) 843-6356. The Massachusetts Medical Society designates this live activity for a maximum of 7.0 AMA PRA Category 1 Credits™.

— Elyse Linson

STATE UPDATE

Ann Hwang, M.D.*continued from page 1*

Dr. Hwang took a non-traditional path to her new position. She spent a year away from medical school at the University of California, San Francisco, to work in Switzerland with Physicians for Social Responsibility.

After completing medical school she won a congressional fellowship with the American Association for the Advancement of Science, working in U.S. Senator Richard Durbin's (D-Ill.) office on global health and HIV issues.

Dr. Hwang described it as being "struck by a bit of Potomac fever and trading 'Grey's Anatomy' for 'The West Wing.'"

Like many of her peer physicians, Dr. Hwang has taken a multidisciplinary approach in her medical training.

"It seems much more common now for physicians to do more

and more training," she said. "Those of us in medicine with 'just' an M.D. may even feel a little more inadequate! Trainees in post-graduate year eight or nine are not unheard of."

Dr. Hwang returned to medicine after her fellowship in Washington, D.C., with a residency in internal medicine at Brigham and Women's, which she completed in 2009.

Q: *What surprises you about working in state government?*

A: "Well, I've traded my pager for a Blackberry, for one thing, and I'm not sure it's any better. I have been impressed at how many smart, hard-working people there are in Massachusetts

"I feel that being a physician in Massachusetts is a lot like being an artist in New York — there is such a sense of community, innovation, and vibrancy. Here is where policy, research, and clinical practice meet."

— Ann Hwang, M.D.

state government. It can be extremely challenging to move forward on big issues like payment and delivery system reform, but under the governor's leadership, this administration has accomplished a great deal."

Q: *What role do you see for practicing physicians working with state government?*

A: "Physician engagement is incredibly important because of the unique perspective practicing physicians bring to policy discussions and decision-making. It is difficult for practicing physicians to come to the Legislature and to the state agencies tasked with implementing regulations and policies, but physicians bring an

important perspective, simply by asking the questions: "How would this policy or regulation work in my clinical practice?" and "What does this mean for my patient?"

Q: *What is the biggest challenge for you working at EOHHS, and what holds the most promise?*

A: "For me personally, it definitely was an adjustment coming from clinical practice. For one thing, I don't think I realized that I would be in meetings every day from 8 a.m. to 5 p.m., so in a way I feel like I don't get to start my work day until after that. But it is a great time to be working in health policy, with the implementation of federal health reform and Governor Patrick's leadership on state health reform.... Our challenge is how to build a system that is innovative and sustainable for generations to come." **VS**

FEDERAL UPDATE

Seeking SGR Changes in 2013

New Payment Formula is Goal

Now that we are well into 2013, we know what the forced federal budget cuts (known as sequestration) mean for most physicians — a 2 percent cut on all services provided on or after April 1, 2013.

Local Medicare carriers took the 2 percent reduction from submitted claims. There were no changes to co-pays for beneficiaries or any changes to the payments by other secondary payers. At this point, the law is clear — it prohibits Medicare or Medicaid patients from being asked to absorb any extra cuts.

In addition to sequestration, the main focus for the MMS, AMA, and other physician advocacy groups this spring continues to be replacing the Medicare Sustainable Growth Rate (SGR) with a more accurate payment formula.

Our goal is to replace the SGR by December 2013, before the next SGR cuts go into effect on January 1, 2014.

Meanwhile, the U.S. Senate passed its first budget resolution in four years in the wee hours of March 24, after more than 13 hours of nonstop votes on 70 amendments.

Although the budget resolution was not binding on policy issues, the votes showed continued deep philosophical and political divides between the parties.

Republican senators, following their House counterparts, offered a series of amendments to rescind or replace parts of the Affordable Care Act (ACA).

While most failed on party line votes, an amendment to repeal the tax on medical device companies passed with bipartisan support. The tax on medical device companies was one of several taxes included in the ACA to help pay for new coverage and services.

In the months to come, we can expect more attacks on the ACA, as well as increased attention from the House and Senate to move a new, sustainable Medicare physician payment formula. **VS**

— Alex. Calcagno



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PHYSICIAN HEALTH MATTERS

Strength-Based Coaching: A Path to Increased Life and Career Fulfillment

Strength-based coaching (SBC) is increasingly being used to enhance performance and well-being for physicians. Whether you're feeling like you're barely surviving the ever-increasing demands of your practice, are out of touch with the reasons you became a physician in the first place, or are looking for a more balanced life, this approach can help you move from feeling stuck to seeing options and possibilities. SBC is designed for high-functioning individuals and is a model of wellness, starting with the premise that you have significant inner resources, wisdom, and expertise regarding your life.

The coach is not a teacher or mentor, but rather a facilitator of change. The coach's role is one of nonjudgmental advocate, ally, sounding board, and champion. A coach helps deepen your self-awareness and strengths to identify inspiring perspectives on what may seem like fixed circumstances, having no agenda other than supportively helping you find ways to move forward and effect sustainable change. SBC draws on hobbies and life passions outside of work and uses humor to help you access alternative ways to view life challenges. SBC can improve your quality of life and can also be helpful for non-clinical skill development or

to deal with anger and other challenging emotions.

Most physicians are achievement-oriented and, from early in our training, the message is clear that if we're not perfect, we are a failure. Many physicians also tend to be harsh self-critics, overlooking accomplishments and strengths and focusing more on their negative than positive traits.

All physicians have strengths! Whether through the popular book, *StrengthsFinder*, or a free online assessment at the University of Pennsylvania Positive Psychology site www.authenticchappiness.org (Values in Action questionnaire), there are well-validated assessments that identify a person's top strengths. Once known, instead of approaching a new task by thinking about weaknesses that need to be overcome, you can start one step ahead by applying your strengths.

Coaches don't "fix" problems; instead they point clients in the right direction to find answers. Here are some ways a strength-based coach would work with a physician:

- Let's think about your top strengths and ways you have used them in the past to get through a tough situation.
- What three things did you do today that helped a patient or colleague?
- Let's brainstorm ways you can apply your strengths to the problem at hand.
- We'll work together to explore the validity of self-defeating messages and replace them with ones that more accurately reflect the truth of your life.

- How can you apply a strength you have in a new way?

After reading this article, perhaps you can think more about your strengths and how you can apply them this coming week.

— Gail Gazelle, M.D., F.A.C.P.
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For more information about Physician Health Services, Inc., please visit our website at www.physicianhealth.org or call (781) 434-4704.

Steve Adelman, M.D., Director, Physician Health Services

As the new director of Physician Health Services, it gives me great pleasure to introduce this article on strength-based coaching by my former colleague Gail Gazelle, M.D., an experienced professional coach. The advent of professional coaching represents an important paradigm shift in how we think about the work we do as doctors. The current state of our profession is such that it may be helpful to think about the career of a doctor like the career of a long-distance runner. Our work lives require us to run this race over and over again, year after year. Just like runners, we face new physical and psychological challenges as we mature and age. The long haul of medical practice adds all manner of alphabet-soup extras (HMO, ACO, ACA, CPT, PBM, etc.) to our bowls as we make our way, day after day, with the ups and downs of delivering health care in 2013 and beyond.

So where does coaching fit in? Elite athletes work with coaches to complete races and optimize their performance. We physicians should think about ourselves as elite athletes who may also benefit from the assistance of such a coach. Athletes — and doctors — who get coached are less likely to require the more intensive, extensive, and illness-based forms of assistance than is the lot of those who lack conditioning. All "deconditioned doctors" should consider investing in their own health, well-being, and self-care.

Volunteer as a BU School of Medicine Faculty Facilitator

Are you retired, working fewer hours, or otherwise finding yourself with free time? Are you looking for a way to apply your medical knowledge through involvement with medical students?

The Committee on Senior Volunteer Physicians offers a suggestion for a unique and rewarding volunteer opportunity. Boston University School of Medicine (BUSM) is looking for physicians to volunteer as faculty facilitators

for its Integrated Problems (IP) Course.

The IP Course is a problem-based learning course taken by all BUSM students throughout their first and second years. Through the discussion of clinical cases the IP Course assists students in integrating information from other courses and developing clinical reasoning skills through small group discussion and individual research. The students meet in small groups for

two hours each week for 10 to 12 weeks between early September and early December. If you become involved, your role will be as a facilitator to their discussions of clinical cases.

If this appeals to you as an exciting and interesting way to apply your medical knowledge through involvement with medical students, plan to attend the free information session on Tuesday, June 4, 2013, at MMS headquarters in Waltham.

**Tuesday, June 4, 2013
9:30 a.m. to 1:00 p.m.**

**MMS headquarters
860 Winter St., Waltham**

Complimentary lunch
will be provided.

If you are interested in attending the information session or have any questions, please call Carolyn Maher at (800) 322-2303, ext. 7311, or email cmaher@mms.org.

LETTER TO THE EDITOR

Dear Editor:

I very much appreciate Dr. Richard Aghababian's *President's Message* (*Vital Signs*, March) regarding medical marijuana. I am writing to highlight his words and expand on them. I realize that many patients with debilitating diseases find relief from marijuana, but that is not the issue at hand. The issue is figuring out how we, as physicians, can safely and responsibly prescribe this substance. One thing that is clear is that making up therapeutic doses of a substance without any science to back it up is irresponsible. For example, the current guidelines would legally allow a pediatrician to approve 10 ounces a month of marijuana for a pediatric patient of any age or size, as long as the parents approved. This is nonsensical and wholly negligent. Yet, the current law allows any pediatrician to do just that.

Perhaps the general public would like marijuana to be a legal substance, like alcohol. If that is the case, then the ballot item should have addressed that desire. But if the general public wants to rely

on a prescription from a physician for a substance, then people must be willing to wait until science can determine its dosing and toxicity. Until we understand the pharmacology of marijuana, the way we do with all the other medications we prescribe, we are simply guessing in our recommendation.

In addition, there is no logical reason for marijuana, as opposed to all other medications, to be dispensed in its own special stores. I cannot understand why marijuana wouldn't be kept behind a pharmacy counter, like all other prescription medications, and dispensed in childproof containers with directions clearly printed on a label, and be subjected to the usual tracking system employed for any other medication. Either society should view marijuana as a medical substance and subject it to the rigors of testing and pharmacologic regulations of all other medications, or society should view marijuana as a recreational substance and allow individuals to experiment with personal dosing. The current status makes no sense at all.

Susan B. Laster, M.D.
Brookline, MA

Letters to the editor should be 200 words or fewer, and all are subject to editing. Send to the MMS Department of Communications, 860 Winter Street, Waltham, MA 02451-1411; vitalsigns@mms.org; or fax to (781) 642-0976.

HIV and STIs in Massachusetts: What All Health Care Providers Need to Know

Despite decades of public health efforts, sexually transmitted infection (STI) rates in the United States have skyrocketed and the number of new HIV cases has refused to budge. This program will address the clinical care of Massachusetts populations at greatest risk for STIs including HIV — particularly sexual minority populations.

Although patients generally feel that clinical settings are an appropriate place to take sexual histories and discuss sexual health and would like their providers to initiate such discussions, providers often have difficulty adequately addressing sexual health issues for a number of reasons, including provider reticence and a lack of training.

By attending this program, providers will be able to take a comprehensive history of sexual health and apply screening guidelines for STIs and HIV in appropriate primary care populations. The latest information regarding HPV vaccinations and understanding situations where Expedited Partner Therapy is warranted to prevent STI re-infection will be highlighted as well. For more information, visit www.massmed.org/HIV2013.

Friday, June 7, 8:00 a.m. to 1:00 p.m.
MMS headquarters

Sponsored by the Massachusetts Medical Society and its Committee on Lesbian, Gay, Bisexual, and Transgender Matters in collaboration with the Sylvie Ratelle STD/HIV Prevention Training Center of New England and National LGBT Health Education Center, The Fenway Institute

ACROSS THE COMMONWEALTH

District News and Events

Essex North/Essex South — Delegates Caucus Meeting. Wed., May 1, 6:00 p.m. Resolution Review. Location: Beverly Depot, Beverly. For more information, contact the Northeast Regional Office.

Norfolk — Delegates Meeting. Wed., May 1, 6:00 p.m. Location: MMS headquarters, Waltham. Discuss resolutions for the AM13 meeting. For more information, contact the Northeast Regional Office.

Suffolk — Delegates Meeting. Thurs., May 2, 6:00 p.m. Location: East Garden Room, MGH. Delegates will meet to discuss resolutions for the AM13 meeting. For more information, contact the Northeast Regional Office.

Art, History, Humanism, and Culture Member Interest Network — Introduction to Bird Watching Lecture. Thurs., May 30, 6:00 to 8:00 p.m. Location: MMS headquarters, Waltham. **Field trip.** Sat., June 1, 9:00 a.m. to noon. Location: Joppa Flats, Newburyport. For more information, contact the West Central Regional Office.

Statewide News and Events

If you have news for Across the Commonwealth, contact Michele Jussaume, Northeast Regional Office, at (800) 944-5562 or mjussaume@mms.org; Sheila Kozlowski, Southeast Regional Office, at (800) 322-3301 or skozlowski@mms.org; or Cathy Salas, West Central Regional Office, at (800) 522-3112 or csalas@mms.org.

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.

Samuel Burgess, M.D., 97; Medford, NJ; Boston University School of Medicine, 1950; died January 19, 2013.

Melissa M. Dowd, M.D., 30; Middleboro, MA; Boston University School of Medicine, 2012; died November 16, 2012.

Paul H. Duray, M.D., 74; Ijamsville, MD; University of Nebraska College of Medicine, 1971; died October 8, 2012.

John G. Ferrante, M.D., 82; Dedham, MA; Boston University School of Medicine, 1962; died December 6, 2012.

Felix Heimberg, M.D., 92; Lunenburg, MA; Harvard Medical School, 1944; died January 4, 2013.

Stanley M. Levinson, M.D., 95; San Francisco, CA; Harvard Medical School, 1941; died March 28, 2012.

Edward Levitz, M.D., 93; Enfield, CT; Middlesex University School of Medicine, 1943; died October 19, 2012.

John Lockhart, M.D., 83; Wellesley, MA; Tufts University School of Medicine, 1959; died October 12, 2011.

John C. Lonergan, M.D., 85; Naples, FL; Tufts University School of Medicine, 1954; died October 2, 2012.

Abdel-Kader Mehio, M.D., 45; Brookline, MA; American University of Beirut, 1993; died May 28, 2012.

Sidney Maislen, M.D., 99; Norwich, VT; University of Vermont College of Medicine, 1938; died January 17, 2013.

Stanley E. Order, M.D., 78; Owings Mills, MD; Tufts University School of Medicine, 1961; died January 19, 2013.

Walter J. Pacosa, M.D., 88; Wilbraham, MA; Tufts University School of Medicine, 1953; died January 21, 2013.

Stephen A. Pap, M.D., 49; Sherborn, MA; University of Massachusetts Medical School, 1996; died March 12, 2013.

Seymour R. Shalek, M.D., 91; Andover, MA; Boston University School of Medicine, 1945; died September 5, 2012.

Sydney M. Sorrel, M.D., 91; Watertown, MA; Boston University School of Medicine, 1945; died October 18, 2011.

Warren E.C. Wacker, M.D., 88; Brookline, MA; George Washington School of Medicine, 1951; died December 29, 2012.

A Dose of "Reality Medicine"



Photo by Robyn Alie

Alice Coombs, M.D., Committee on Diversity in Medicine student member Eduardo Hariton, and committee chair Lenny Lopez, M.D., M.Div., M.P.H., at the MMS Reality Medicine networking event, which brought together experienced physicians and medical students from the four Massachusetts medical schools, residents, and fellows to discuss issues of race, ethnicity, health care, and career choices.

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MASSACHUSETTS
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VITALSIGNS

VOLUME 18, ISSUE 5, MAY 2013

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LIVE CME ACTIVITIES

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

MMS Ethics Forum — Conflicts of Interest in Medical Publishing
Thurs., May 9, 3:30 to 5:30 p.m.
Seaport World Trade Center, Boston

Annual Education Program — Navigating the Currents of Change: Integrating Innovative Technologies into Your Clinical Practice
Fri., May 10, 8:00 a.m. to 12:15 p.m.
Seaport World Trade Center, Boston

Shattuck Lecture — Chronic Infectious Disease and the Future of Health Care Delivery
Fri., May 10, 12:30 to 2:00 p.m.
Seaport World Trade Center, Boston

2013 MMS and RIMS Directors of Medical Education Conference
Thurs., May 16, 1:00 to 5:30 p.m.

Home-Based Palliative Care for Patients with Serious Illness: A Team Approach
Mon., May 20, noon to 1:30 p.m., via live webinar

A Roadmap to Bring an End to HIV and STIs in Massachusetts: What All Health Care Providers Need to Know
Fri., June 7, 8:15 a.m. to 1:00 p.m.

Assessing Medicine, Mental Health, and Cultural Needs During Sheltering
Tues., June 11, 5:15 to 8:00 p.m., live conference held in Waltham and via streaming webinar

11th Annual Symposium on Men's Health: Topical Issues in Men's Health
Wed., June 12, 8:00 a.m. to 5:00 p.m.

ONLINE CME ACTIVITIES

Go to www.massmed.org/cme.
Risk Management CME

End-of-Life Care

- The Importance of Discussing End-of-Life Care with Patients*
- *Legal Advisor:* Advance Directives*

Pain Management

- *Legal Advisor:* Identifying Potential Drug Dependence and Preventing Abuse*

- Managing Risk when Prescribing Narcotic Painkillers for Patients*

Legal Risk Management CME

- Active Listening as a Tool for Improved Doctor-Patient Relationship
- Legal Duties and Options when a Patient Raises Suicide
- *Legal Advisor:* Boundary Violations

Other Risk Management

- Avoiding Failure to Diagnose
- Getting it on Record and Getting it Right
- Medical Mistakes: Learn to Steer Clear of the Common Ones
- The Changing Nature of Informed Consent
- Dealing with the Changing Dynamic of Medical Staff
- Data Analytics Module 1: Population Health Management
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- Data Analytics Module 3: Improving the Health of Your Patients
- Social Networking 101 for Physicians

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