“Let’s Change the Conversation Around How We Look at Guns”

AG Healey on Physicians, Patients, and Gun Violence

By Robyn Alie
MMS Public Health Manager

Attorney General Maura Healey cited gun violence as a priority for her office. Vital Signs spoke with her about the issue.

VS How would you describe the problem of gun violence in MA? Does it differ from other states?

AG Healey Massachusetts has one of the lowest rates of gun deaths in the country. That said, we see far too many of our residents die tragically and senselessly because of guns. We see gun violence manifest itself in different ways: sometimes it involves a mental health concern. A high percentage of gun deaths are suicides. We have an issue with respect to gang violence, and we’ve seen shooters at an increasingly younger age, and that’s really disturbing when you’re talking about 12-, 13-, 14-year-olds with guns shooting at one another or other people.

Massachusetts has some of the strongest gun laws and regulations in the country. I think it’s really important that we do everything we can to take steps to put an end to irresponsible and illegal gun use and sales.

VS You have called this problem a public health problem. Why?

AG Healey [According to] studies from the American Public Health Association, 91 Americans are killed with guns on average each day, which is close to 35,000 people annually. In an average month, 61 women are shot to death by intimate partners. At least seven kids or teenagers are killed a day by guns in this country. For 2013, gun-related deaths, 62 percent were suicides. And another thing for me that’s important: guns are the leading cause of death for black men ages 13–34.

In the same way we changed the conversation around opioid prescriptions, let’s change the conversation around how we look at guns. It’s divisive when it comes to speaking about this issue as a second amendment issue. I believe in the second amendment, I respect the second amendment. That’s not a question. But it really bothers me when you have efforts to prevent the study of this as a public health matter, given the serious impact it’s had on public health. Not just for individuals — those who were shot, those who were killed, those who were doing the shooting, it has such a profound impact not just on individuals and families but also on entire communities. And that’s why I think it needs to be viewed as a public health issue and as a public health issue, by definition, it needs the involvement and work and support of the medical community.

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A Letter from Corinne Broderick

Corinne Broderick, MMS executive vice president, will retire next month after 32 years of service to the Society. Her successor, Lois Dehls Cornell, J.D., will assume leadership of the MMS on June 1.

Dear Friends,

It has been an honor and a privilege for me to have served the MMS for these past 32 years. I have seen many changes both in medicine and in the Medical Society through this time, and I appreciate the opportunities to have worked with so many incredible physicians and staff colleagues.

Working as your executive vice president for the past 15 years has been a tremendously fulfilling professional experience. Thank you all for the chance to make a difference. I certainly will miss you and wish only great things for this medical society in the years ahead.

Sincerely,
Corinne

What You Must Know About the New Opioid Laws

MMS Opioid Legislation Practice Guide Now Available

All Massachusetts physicians are immediately subject to many of the new provisions in the opioid prescribing law passed in March. These include several new legal requirements related to opioid prescribing which became effective immediately and should be incorporated into your clinical practice.

Unless otherwise noted, these provisions became effective March 14, 2016.

The law imposes a seven-day limit on prescribing of opiates to a patient for the first time. Provision applies to minors for every such prescription, with parental notification. For outpatient cases only. Exceptions for acute medical conditions, chronic pain, cancer and palliative care.

Other highlights of the law related to the practice of medicine include the following:

- Prescribers must check the Prescription Monitoring Program (PMP) every time for a Schedule II and III narcotic is prescribed. The law maintains current statutory language requiring regulations to recognize circumstances under which such narcotics may be prescribed without first

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PRESIDENT’S MESSAGE

Thank You for a Special Year
As my presidency draws to a close, I wanted to reflect on the very eventful year that is almost complete.

In my first President’s Message for Vital Signs, I wrote about our need to participate in a new effort at opioid awareness and abuse prevention. In that message, I wrote of my belief in our members’ willingness and ability to make an impact in curbing the nation’s opioid abuse epidemic.

A year later, I can say that the Society rose to the challenge. Massachusetts physicians have led the way in changing the approach to pain control and prescribing, as well as how we educate patients about opioid safety. I am proud of the work the MMS has done.

My final President’s Message would not be complete without reflecting on the terrific tenure of our executive vice president, Corinne Broderick, who retires this month. Like every great leader she leaves this organization better than she found it. Her intelligent, calm, and wise stewardship has been critical to the success of the MMS, and I know that I speak on behalf of every other president of the last 15 years when I say that Corinne made any successes we may have had possible.

As I too prepare to leave, I want to extend my deepest thanks to all of the physicians who work so hard and volunteer their time to this medical society, and send my best wishes to my successor Jim Gessner. It has truly been an honor serving as your president.

Thank you.

— Dennis M. Dimitri, M.D.

Women in Medicine: Charting Progress
JAMA Data Shows Women MDs Still Suffering Pay Gaps

BY VICKI RITTERBAND
VITAL SIGNS STAFF WRITER

It wasn’t that long ago that a female surgeon in a powerful hospital leadership position in Massachusetts was offered an employed position at a substantially lower base salary than that of the male junior surgeon she had helped recruit. She accepted the position, but it still stung.

While medicine has become a far friendlier profession for women in recent decades, significant disparities in pay persist, even after adjusting for practice type and hours, according to a 2013 JAMA Internal Medicine study. Female physicians on average earn $56,000 less than males, according to the study, which examined salary data between 1987 and 2010.

And while women are well represented in the worlds of research, academic, and organized medicine, you’re more likely to find a male at the top than a female. Women comprise more than a third of U.S. medical school full-time faculty, yet only 15 percent of department chairs and 16 percent of medical school deans, according to the Association of American Medical Schools’ 2014 Women in Medicine and Science Benchmarking survey.

Boston University School of Medicine Dean Karen Antman, M.D., says that in her experience, women physicians are more likely to decline leadership opportunities than their male counterparts. “I have offered chairs of departments to very qualified women who turn down the position,” says Dr. Antman, a medical oncologist. “Then it’s offered to a man who may not be as qualified but they’re almost always willing to take it.”

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LETTER TO THE EDITOR

Support Responsible Adult Use of Marijuana in November

Dear Editor: The objectives of the Regulation and Taxation of Marijuana Act, the ballot question that will be presented to Massachusetts voters in November, addresses concerns of MMS physicians such as protection of public health and safety; protection of children and teens; standardization; regulation at the dispensaries control by municipalities; protection of employers and landlords; and elimination of a black market.

The ballot question realizes we cannot change human nature. It understands prohibition is a dangerous and failed public health policy.

— Eric J. Ruby, M.D., Taunton, MA

Women and Organized Medicine Leadership

Women are still having a difficult time penetrating the highest ranks of organized medicine as well. Norfolk District Medical Society president, immunologist/allergist Lynda Kabbash, M.D., said that she was disappointed when she applied for leadership positions at the American Medical Association and the American Academy of Allergy, Asthma & Immunology and received form letters telling her she hadn’t been chosen for either. “Diversity doesn’t happen by chance,” she explained. “These are missed opportunities to encourage women to pursue leadership by acknowledging their contributions in a more personal way and suggesting other ways to apply their talents.”

MMS Members: Confirm Your Website Password

In mid-April, the MMS upgraded its member database. That system stores your username and password for the MMS website. For that reason, the first time you visit the MMS website after the upgrade you will be asked to confirm your password. You will have to do this only once.

For more details about this transition period, visit www.massmed.org/trans formation or contact MMS Customer Service at (800) 843-6356.

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The Salary Gender Gap

Gender equity shouldn’t be too far in the future. After all, women comprise about half of U.S. medical students and are working in specialties that a generation ago were almost exclusively male.

Some blame salary differences on the fact that women are under-represented in some of the highest paid specialties, a fact that the JAMA study didn’t factor into its findings that the average male doctor earned about $221,000 annually in the years between 2006 and 2010, and the average female doctor — $165,000.

“The usual excuses for explaining a salary gender gap in medicine are specialty choice, family and child-rearing responsibilities, or working a part-time schedule,” said the surgeon who was offered the lower salary. “But those don’t bear out in the studies that control for those variables, and as a single woman surgeon, those were not part of the equation for me.” She asked not to be named in Vital Signs, fearing repercussions to her career.

“We have been able to get rid of the most overt sexist behavior, but it’s the subtler stuff that adds up, like death from a thousand paper-cuts — the microaggressions and gender biases,” she said. “You wonder if they are real, or if you’re being too sensitive — until you talk with others and realize it is a shared experience.”

Internist Natalie Pauli, M.D., is a trailblazer, but still, her career took a backseat to her neurosurgical husband in the operating room.

Changing Landscapes

Like Dr. Rockett, Dr. Pauli, 38, is married to a physician, whose demanding career as a fertility specialist has also made her the default parent. “It doesn’t mean he’s less of a parent, but the fact is I don’t make as much money as he does. If I don’t go to clinic, it’s not as much of an income loss. If he doesn’t go, it’s a bigger deal.” As a result, his attention to his career has been less divided than hers. “My husband gets dressed, leaves the house and that’s it. He’s not worried about one of our kids getting sick and his whole plan for the day falling apart. The school doesn’t call him, they call me.”

But one key difference between Dr. Rockett’s and Dr. Pauli’s generation is the workplace. In the all-female Brigham and Women’s women’s health practice where Dr. Pauli works, the double-lives of the physicians are accommodated. No one works full-time and “there’s a lot of camaraderie and support,” explains Dr. Pauli, who has two daughters ages 6 and 8. “If you have to run to pick up your kid, that’s OK.”

And that respect of the work-life balance often begins as early as medical school. Fourth year UMass Medical School student and mother Aimie Zale, 35, would sometimes arrive late to morning classes in her second year because she had to drop off her kids at school. Her instructors were understanding. “UMass recognizes that physicians are people and have responsibilities outside of the exam room,” she comments. “There is not just one path to medicine.”

Are You Having Problems Getting Paid?

The MMS Regional Offices are happy to announce that the annual Individual Claims Consultation Days will be taking place during the months of July and August. These in-person trouble-shooting sessions are designed to allow MMS member physicians and their practice staff to schedule 30-minute appointments with health plans in order to focus on adjudication of troublesome claims.

Representatives from the health plans listed in the table will be on hand to review claims with physicians and their office staff in order to facilitate claims processing. New this year, practices can schedule appointments online for an upcoming Individual Claims Consultation Day session. To schedule your appointment today, please visit www.massmed.org/iccdays2016.
Warm Weather Exercise Brings Risk of Heat-Related Illness

There were 28,000 running events in 2014, according to RunningUSA.org, with half-marathons and marathons increasing in popularity. Running and training for these races can be great ways to get and stay fit. “Participating in these events can be fun, and can help build your social network of people who are physically active,” said Denise Rollinson, M.D., chair of the MMS Committee on Nutrition and Physical Activity. “And, if you have buddies, it can improve your mental health and commitment.”

With warm weather approaching, Dr. Rollinson, who is an emergency physician, a registered dietitian, and medical director for Boston’s Run to Remember, as well as an avid runner herself, provides some words of caution to help runners avoid heat-related injury, illness, and even death.

“I see people participating in races who have not trained enough for the race that they’re in. They’re not physically prepared for the race, and are risking injury, heat illness, particularly in endurance events,” she said. “There have been tragic cases where people have gone out drinking beforehand, gotten dehydrated and died.”

Those new to exercise are advised to see their doctor before beginning an exercise program, and should start slowly. Dr. Rollinson recommends an EKG for any individual who has a family history of heart disease or sudden death. Those with underlying conditions, such as diabetes, heart, or respiratory issues, should take their exercise programs more slowly.

Runners should be aware that they can get overheated without realizing it, and dress appropriately, recognizing that they’re going to warm up as they exercise and as the day gets hotter, said Dr. Rollinson.

Rollinson recommends runners acclimate to the heat, and know their own bodies, and stop running when they’re getting fatigued or overheat-ed. She also recommends running with a friend who might notice mental status changes.

The American College of Sports Medicine highlights the importance of education, planning, acclimatization, modification, and monitoring when participating in outdoor physical activity. They also recommend drinking fluids before and occasionally during exercise, to provide adequate hydration.

“People should feel free to walk these races,” said Dr. Rollinson, adding that they would intercede and break cycles of violence, break cycles of trauma in communities. A lot of this effort requires funding and I think that the MMS has such a powerful platform and can be such a powerful voice. Because people, I think uniformly, care about their health. We may disagree along very political lines on various issues, but people care about their health, they care about their kids’ health. We just haven’t talked about it enough as a society. We haven’t approached it through this lens. Hopefully by speaking about it and raising it, maybe there’ll be more instances where we identify people who may be harmed by themselves or others and get them the services that are needed — protect potential victims that much sooner. Because strictly as a law enforce-

ment matter, I don’t think we have all the answers or the solution. But it is something that we all need to focus on. Not only does violence at times beget violence. But the cost and impact on victims and survivors is so profound and presents all sorts of mental, physical, and emotional health issues for those people, and for their families, and for the entire community. Massachusetts is no better place to engage in this discussion and take it on.

VS How do you reframe the conversation? How do we talk about this as a legitimate issue and a political issue.

AG HEALEY We’ve been there. We’ve done that.

Hearing the political discourse now with the presidential election, there will be those discussions, there will be that debate. But I’m sort of moving past that, to look at what’s going on with underlying trauma and violence in homes, on our streets, and in our communities. To me, this is a public health matter. Just look at the number of people who have died, who continue to die each day, each year, and thanks to medicine, look at all the victims that are out there that do survive. But it’s something that we all need to focus on. Not only does violence at times beget violence. But the cost and impact on victims and survivors is so profound and presents all sorts of mental, physical, and emotional health issues for those people, and for their families, and for the entire community. Massachusetts is no better place to engage in this discussion and take it on.

VS How do you reframe the conversation? How do we talk about this as a legitimate issue and a political issue.

AG HEALEY One thing would be [for] the CDC to actually study this. For years, the gun lobby worked hard to get a law in place that banned the CDC from studying this issue. To me it’s sort of amazing: you think about the number of people dying from this every day. We study all sorts of things, whether it’s car accidents, and all sorts of medical issues, and here we have this issue and Congress has banned the CDC from studying it. To me, that’s ridiculous. That needs to be changed.

VS Is there something the MMS and physicians could do to help change that conversation?

AG HEALEY I think they have a really important role to play in changing that conversation, in talking about it with their patients, in talking about it with their colleagues, and supporting efforts to allow this issue to be studied and talking about as a public health matter, so people really understand what’s happening and the consequences of what we have in place in terms of laws — the consequences of not adequately providing resources that would help intercede and break cycles of violence, break cycles of trauma in communities. A lot of this effort requires funding and I think that the MMS has such a powerful platform and can be such a powerful voice. Because people, I think uniformly, care about their health. We may disagree along very political lines on various issues, but people care about their health, they care about their kids’ health. We just haven’t talked about it enough as a society. We haven’t approached it through this lens. Hopefully by speaking about it and raising it, maybe there’ll be more instances where we identify people who may be harmed by themselves or others and get them the services that are needed — protect potential victims that much sooner. Because strictly as a law enforce-

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VS Is Massachusetts positioned to be a leader on this issue, in changing the conversation?

AG HEALEY Absolutely. When it comes to health, public health, and innovation, and the medical profession, Massachusetts leads the way. I think we have a tremendous opportunity here in this state to really raise the consciousness on this issue and push to shift the lens on this and have it seen as a public health issue. I think we’re uniquely situated among all the states to do just that because of the excellence of the health care profession here and the medical profession here in particular.

We’ve got to do something in this country. We just can’t let gun violence be our new normal. It’s amazing to me that we’re now at a point where little kids go to school and alongside their math and science lessons they’re learning how to prepare for an active shooter — things that were unimaginable, at least when I was growing up. I don’t pretend to have all the answers or the solution. I just think that this just cannot be. We need to get a handle on this as a country, and I think that the medical profession has a real role — an important role — to play in this. And for us to be successful, given the multifaceted nature of this problem, we’ll need a real mix of stakeholders and partners at the table. And the medical community is and will be a really terrific partner in this effort.
utilizing the PMP, and permits delegates to use the PMP on behalf of the prescriber. Effective Oct. 15, 2016.

• The law allows patients to request a partially filled opioid prescription. The pharmacist must notify the prescriber within seven days. Prescribers must discuss with the patient the quantity of the prescription and the option to partial fill. Remainder of the prescription becomes void.

• All prescribers must complete appropriate training in pain management and addiction, to be determined by boards of registration.

• Prior to issuing an extended-release long-acting opioid in a non-abuse deterrent form for outpatient use for the first time, a practitioner must evaluate the patient’s current condition, risk factors, history of substance abuse, if any, and current medications; and inform the patient and note in the patient’s medical record that the prescribed medication, in the prescriber’s medical opinion, is an appropriate course of treatment based on the medical need of the patient.

• The law requires the Department of Public Health to establish a voluntary non-opiate directive form, indicating to all practitioners that an individual shall not be administered or offered a prescription or medication order for an opioid. Directive may be revoked at any time, in writing or verbally. Directive to be recorded in patient’s medical records. Exemptions for emergencies. Liability protections for prescribers and pharmacists. Effective Dec. 1, 2016.

• The law establishes a benchmarking mechanism for prescribers. The Department of Public Health determines mean and median quantity and volume of prescriptions for opiates, within categories of similar specialty or practice types. Prescribers who exceed mean or median will be sent notice. Rankings are confidential, are not admissible as evidence in a civil or criminal proceeding, and are not to be used as the sole basis for an investigation by the board of registration. Effective Dec. 1, 2016.

• The law requires overdose and naloxone patients in emergency departments to undergo a substance abuse evaluation by a licensed mental health professional or through an emergency service program within 24 hours. Patients can’t be discharged before 24 hours or before evaluation, whichever comes first. Clinicians cannot be held liable in a civil suit for releasing a patient who does not wish to remain in the emergency department after stabilization but before a substance abuse evaluation has taken place. Parents of overdose minors must be notified. Emergency departments must notify a patient’s primary care provider, if known. Private insurers must pay for substance abuse evaluations without prior authorization. Effective July 1, 2016.


New Opioid Laws
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Open Enrollment for the Legal Advisory Plan is here

Watch your mail and email for enrollment/renewal materials or log in at www.massmed.org to enroll.

For questions, email lap@massmed.org or call (781) 434-7311.
We recently reviewed more than 90 consecutive referrals to Physician Health Services, Inc. All of these physicians and medical students contacted PHS to request services during a six-month period in 2015. The services we provided include support, consultation, assessment, triage, and long-term oversight (monitoring). This article summarizes some of the findings and conclusions that we can learn from these 90-plus referrals.

We are looking at the tip of a very large iceberg. There are approximately 30,000 medical students, residents, and practicing physicians in Massachusetts. These 90 referrals — of which 40 percent were in cases in which doctors referred themselves — are a subset of more than 400 individuals who make use of PHS services in a given calendar year. This N of 400 includes new referrals, ongoing monitoring clients, and individuals who make use of any of our affiliated physician support groups throughout the state. Our penetration rate of nearly 1.5 percent compares favorably with other robust state physician health programs. Nonetheless, the majority of physicians with significant health challenges are not taking advantage of our confidential, free, peer-review protected program. Many of the physicians who come our way have been “sitting on” a worrisome, progressive health problem for months or years. Unfortunately, our culture of putting the care of others ahead of our own care is still alive and well.

We are excited by the growing number of self-referrals. Our review demonstrates that self-referrals now exceed 40 percent of new PHS clients. Increasingly, we are recognized as a helpful resource for doctors and medical students who are eager to get help before a problem or difficult situation starts to get in their way and leads to “the wrong kind of attention.” Although many of these self-referrals involve concerns regarding stress, burnout and work-life balance, others involve psychiatric and substance-related challenges. In general, self-referred PHS clients make excellent use of one or two meetings at PHS, and they use the information and suggestions provided to get the help they need. Their anonymous and unsolicited feedback has been uniformly enthusiastic. Here’s what one of them wrote in a follow-up questionnaire: “It is amazing that such help exists. I do not think I would have gone to see anybody [to get help] otherwise.”

It’s not your grandfather’s or your father’s PHS. More than three decades ago, PHS originated as the Impaired Physicians’ Committee of the MMS. We were a life raft for physicians with career-threatening alcoholism and drug addiction. These days, we endeavor to get involved and help out before your career is threatened by impaired performance, and our scope has expanded to include other mental disorders, non-psychiatric health conditions (such as subtle cognitive decline), and a variety of occupational health challenges. These occupational health challenges include stress, burnout, work-life imbalance, unprofessional behavior, disorganization, and communication difficulties. Our recent review indicates that almost half of the 93 consecutive referrals were in this “occupational health” space. The remaining referrals were almost equally split between mental health challenges and substance-related problems, along with a handful of referrals that involved an underlying medical or neurological problem.

In summary, you are welcome to contact us at any time to confidentially discuss any concerns you have about your own health or the health of a colleague. We’ll do what we can to point you in a healthy direction by drawing on our experience helping the more than 2,600 other doctors and medical students who preceded you.

If you are interested in attending a PHS support group, please contact Physician Health Services at (781) 434-7404, or visit our website at www.physicianhealth.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.

John Brodeur, M.D., 86; Wayland, MA; National University of Ireland, 1960; died February 28, 2016.

E.R. Breitwieser Dunning, M.D., 93; Bethlehem, PA; University of Pennsylvania School of Medicine, 1945; died August 31, 2012.

Romany H. Grigis, M.D., 82; Webster, MA; Abbasis Faculty of Medicine, Cairo, 1956; died May 24, 2015.

Alexander N. Gunn, II, M.D., 79; Sacramento, CA; Northwestern University Medical School, 1962; died March 11, 2016.

P. Randolph Harris, M.D., 85; Westwood, MA; Columbia University College of Physicians and Surgeons, 1958; died March 31, 2016.

Albert C. Lesneski, M.D., 78; Westford, MA; Columbia University College of Physicians and Surgeons, 1963; died April 8, 2015.

William F. O’Toole, M.D., 83; Centerville, MA; Hahnemann Medical College, 1947; died June 8, 2015.

Michael Schiff, M.D., 84; Topsfield, MA; Boston University School of Medicine, 1956; died June 2, 2015.

Mehdi Sarkarati, M.D., 76; Newton, MA; University of Tehran, 1965; died January 10, 2016.

Myron Siner, M.D., 84; Wellesley, MA; Oxford University Medical School, 1961; died July 1, 2015.

David L. Smith, M.D., 95; Acton, MA; Boston University School of Medicine, 1946; died June 8, 2015.

William J. Zukel, M.D., 92; McLean, VA; Hahnemann Medical College, 1947; died August 10, 2014.

14th Annual Symposium on Men’s Health

Current Issues in Men’s Health

Thursday JUNE 16, 2016
8:00 a.m. to 12:00 p.m.

Massachusetts Medical Society Headquarters at Waltham Woods, Waltham, Massachusetts

CME

Provided by the Massachusetts Medical Society and its Committee on Men’s Health
BUSM Integrated Problems Course: A Volunteer’s Perspective
New Volunteers Needed, Orientation June 16

BY AMY VEALE, M.D.

Over the past two years I have had the pleasure of facilitating the Boston University School of Medicine (BUSM) Integrated Problems (IP) 1 and 2 Courses, under the direction of Dr. Megan Young. I first became aware of the opportunity for volunteers through this very MMS newsletter.

As both a physician who was in the process of changing my practice situation and as an alumnus of BUSM, the experience sounded intriguing; after attending the session, I decided to participate. It has been a valuable, enjoyable, and fulfilling experience that I look forward to each week.

Small Groups
During the course of a semester, while working in small groups of five to seven students and one faculty facilitator, first and second year IP course students apply and integrate basic science knowledge learned in their courses, as well as from individual and group research to a series of clinical cases.

They are asked to identify pertinent facts and issues relevant to the case, and discuss additional information needed and questions they would ask to further evaluate the patient. They are then encouraged to develop and modify a systematic differential diagnosis based on the clinical information presented and researched.

Encouraging Students
The course allows students to develop research and presentation skills and collaborative clinical reasoning skills, which will prepare them for their third- and fourth-year clinical rotations.

In my role as facilitator, I encourage the students as a group to run the session, providing support and guidance with the class format and flow. On occasion, I will share anecdotal information or thoughts from my clinical experiences, but for the most part, I let the students — as a group — process the patient cases to their conclusions. I encourage the students to take risks, to ask questions, and to share and explain their thoughts and opinions. I also encourage them to become more comfortable in accessing the research resources available to them when faced with questions about a patient case, a lifelong skill that is helpful to develop at this stage in their training.

Personal Reward
The students whom I have had the opportunity to work with are bright, respectful, and enthusiastic learners. It is rewarding for me to get to know the students and to meet with them individually to talk about their backgrounds, experiences, and plans. I enjoy observing the students progress over the course of the semester, becoming more confident in their clinical reasoning skills, problem solving techniques, communication and presentation skills. I thoroughly enjoyed the experience of working with the students and feel as though I learn something new from them each week. Facilitating the BUSM IP course is an experience that I would highly recommend to any physician who is looking for a new volunteer experience, a teaching experience, or involvement with medical school student education.

The Committee on Senior Volunteer Physicians is sponsoring an orientation session on Thursday, June 16, 10 a.m. to noon. Learn more about how you can participate in this program and become involved with the training of our future doctors. Dr. Meghan Young will conduct the session to explain the program and answer your questions. A complimentary lunch will be served.

Please contact Carolyn Maher at (781) 434-7311 or cmaher@mms.org to register.
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LIVE CME ACTIVITIES

Unless otherwise noted, event location is MMS Headquarters, Waltham.

Ethics Forum: Patient Satisfaction Surveys — Utility and Unintended Consequences

Annual Education Program — Sustaining Joy in the Practice of Medicine: Compassion, Innovation, and Transformation
Fri., May 6, 2016, MMS Annual Meeting, Boston, or via live webinar

2016 Shattuck Lecture — Lost in Translation? Turning Scientific Discoveries into Medical Progress
Fri., May 6, 2016, MMS Annual Meeting, Boston

Being Prepared for the Unexpected: Building Resilient Communities
Wed., May 18, 2016

MMS and RIMS Directors of Medical Education Conference
Thurs., May 19, 2016

14th Annual Symposium on Men’s Health
Thurs., June 16, 2016

ONLINE CME ACTIVITIES

Risk Management CME

Electronic Health Records Education (3 modules)
   - Module 1 — EHR Best Practices, Checklists, and Pitfalls
   - Module 2 — Making Meaningful Use Meaningful: Stage 1
   - Module 3 — Making Meaningful Use Meaningful: Stage 2

End-of-Life Care
   - End-of-Life Care (2 modules)
   - End-of-Life Care (3 modules)
   - The Importance of Discussing End-of-Life Care with Patients
   - Advance Directives (Legal Advisor)
   - Principles of Palliative Care and Persistent Pain Management (3 modules)

Pain Management and Opioid Prescribing
   - Managing Pain Without Overusing Opioids
   - The Opioid Epidemic (6 Modules) — MMS 11th Annual Public Health Leadership Forum

- Principles of Palliative Care and Persistent Pain Management (2 modules)
- Opioid Prescribing Guidelines in Practice
- Opioid Prescribing Series (6 modules)
- Identifying Potential Drug Dependence and Preventing Abuse (Legal Advisor)
- Managing Risk When Prescribing Narcotic Painkillers for Patients (Legal Advisor)

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

Additional Risk Management CME Courses
   - Initiating a Conversation with Patients on Gun Safety
   - Intimate Partner Violence
   - Understanding Clinical Documentation Requirements for ICD-10
   - ICD-10: Beyond Implementation
   - Prostate Cancer and Primary Care
   - Cancer Screening Guidelines (3 modules)
   - Preventing Falls in Older Patients: A Provider Toolkit
   - HIPAA 2.0: What’s New in the New Rules?
   - Impact of Effective Communication on Patients, Colleagues, and Metrics (2 modules)
   - Effective Chart Review for Quality Improvement

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

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