Tales from Two Doctors: Duo Discusses Differences Between Employment and Independence

Both Feel Optimism, Would Choose Medicine Again

BY DEBRA BEAULIEU-VOLK
VITAL SIGNS STAFF WRITER

Behind every survey report characterizing physician attitudes and perspectives at large, there are the individual doctors whose stories bring the statistical picture to life. The findings of the recent 2014 Survey of America’s Physicians: Practice Patterns and Perspectives, the Physicians Foundation’s biennial survey of 20,000 U.S. doctors that examines physician morale, is no exception. The survey data confirmed stark differences in the outlook between employed and private practice physicians, in particular, so Vital Signs spoke with doctors from each setting to gain greater insight into their experiences.

Pierre Rouzier, M.D., practices sports and family medicine as a staff physician at a practice in Amherst. He acknowledged his ideas about medicine may be “skewed toward the positive” because of his employment status and patient population.

On the other hand, Katherine J. Atkinson, M.D., who runs a separate family practice in Amherst, admitted that she often feels “beaten down trying to practice medicine in this day and age.”

Nonetheless, there are distinct threads of optimism that both doctors hold in common, as evidenced by their reactions to the findings from the report.

Physician Morale is Rising

According to the survey, 44 percent of physicians characterize themselves as somewhat or very positive about the current state of the medical profession, compared to just 32 percent in 2012. The apparent improvement in morale came as a surprise to Dr. Atkinson, who has experienced firsthand the frustration of patients avoiding care as their copays and deductibles rise.

“However, I do feel that there’s more optimism that the Affordable Care Act is going to make health care more accessible to everybody. It’s been really hard to take care of people that didn’t have insurance, so the idea that we might be closer to getting universal health care gives us optimism,” she said. “The idea that someday everybody will be able to get health care keeps me going when I’m feeling discouraged.”

Similarly, Dr. Rouzier has witnessed the consequences of formerly insured patients’ coverage getting worse while insurance access improves for those who were previously uncovered. He recounts a case involving a patient suffering from an obstructive gallstone who refused to be admitted through the emergency room before surgery because her ER copay was $1,000. “So it’s getting harder to do medical care because of the financial burdens that are on people that used to have better insurance,” he said.

But he also sees some benefits to patients becoming more cost aware. “One positive thing is that patients used to come in and sort of demand an MRI as soon as they tweaked their knee. Now they know they’re going to have an imaging copay, so they think twice before demanding that MRI,” he said. “From that perspective it makes people appreciate responsible testing versus whimsical testing.”

Employed Physicians Less Stressed

Less surprisingly, the Physicians Foundation report also stated that 51 percent of employed physicians are optimistic about the current state of the medical profession, compared to 33 percent of physicians who own their practice. Dr. Rouzier knows he has fewer headaches than many of his private-practice peers. “Working in college health and doing sports medicine, most of my patients are motivated and somebody else deals with all the problems with insurance,” he said. “I’m not representative of people

continued on page 2

Four New Medicare Rules Could Undermine Your Hospital Medical Staff

The Centers for Medicare and Medicaid Services has finalized controversial new regulations that could undermine the power of hospital medical staffs throughout Massachusetts.

The rule was implemented in July over the strenuous objections of the American Medical Association, the MMS, and 80 other state and specialty medical societies.

In a letter to CMS Administrator Marilyn Tavenner, MMS President Richard S. Pieters, M.D., said the rules could substantially reduce the ability of local physicians to participate in hospital decision-making and further disenfranchise community physicians.

The four rule changes of particular concern are as follows:

1. CMS removed the requirement that each hospital must have its own independent medical staff. Hospital systems may now ask each hospital medical staff if it wants to integrate into a unified medical staff for the entire system. However, this integration can only occur if a majority of the hospital medical staff votes to join the unified staff. “Majority” is defined by the bylaws of each respective medical staff.

If medical staffs of various hospitals are unified into a single body, the unified medical staff is required to take into account each member hospital’s unique circumstances, including the unique characteristics of their patient populations. The unified staff...
**LETTER TO THE EDITOR**

Dear Editor: The front page of the October issue of *Vital Signs* is adorned by the faces of four smiling physicians. I wouldn’t be smiling in their position.

As a retired hematologist-oncologist who was also engaged in palliative care, I view with apprehension the current furor over the availability, even the existence, of opiates. We are here to alleviate pain. Let’s not make that even more difficult by ill-conceived constrictions on physicians and patients that overlook the great value of these drugs. We are not the police.

As I look at the second article, on the compulsion of physicians to “show proficiency in electronic health records as a condition of licensure,” I can only conclude that secretarial skills in a form acceptable to the current vendor have now become of value equal to all we have learned from our years of education, training, and experience in helping the sick. Then, when reading page 3, though in ignorance, I cannot help a frisson of anxiety at what must be still further incursions on practice privacy, time, and bottom line by compliance (frightening word) program and by the “new Registered Provider Organization Program,” whatever that may be.

Allowing micromanagement by politicians, bureaucrats, regulators, insurers, and vendors will leave nothing for us to macromanage.

– Harvey E. Finkel, M.D.

Brookline, MA

---

**Tales from Two Doctors**

continued from page 1

in primary care battling to get reimbursed and having a whole panel full of patients that don’t take care of themselves and frustrate them to no end. If I were that person, I’d give you totally different answers.”

Indeed, Dr. Atkinson faces many such challenges daily. “We [in private practice] get nickeled and dimed about everything and there are months that it’s hard for me to meet payroll,” she said. For example, she noted that in order to attest to the next level of Meaningful Use, it’s not enough that she already e-prescribes. “Now, every time I e-prescribe, I need to click three more buttons in order to get meaningful use. The three buttons, as far as I can tell, do not improve patient care one iota,” she said. “But because I need the money to stay afloat, I need to add all of these extra buttons.”

What’s more, Dr. Atkinson said she is paid less today by almost all insurers than she was five years ago, and that she loses $60 every time she sees a MassHealth patient.

To that end, Dr. Atkinson explained that many of her colleagues fit into the bucket including the 39 percent of survey respondents who indicate that they will accelerate their retirement plans due to changes in the health care system. “I’m seeing that every day,” she said. “In our area, most of the primary care docs have left practice or left the state. They’re either doing cash-based practice or selling alternative things or they’ve gone to work for systems that can salary them like the VA. It’s very hard to work the kind of hours we work, have the expectations that are placed on us, and get the kind of revenues we get.”

Dr. Rouzier, a 1984 medical school graduate, is quick to include himself among the more than 70 percent of surveyed physicians who say they would choose a career as a physician if they had to do it over again, as well as the 49 percent who would recommend a career in medicine to their children.

In fact, he said he recommends medicine not only to his own children but also to the students he advises at the University of Massachusetts. “I challenge the people who tell them not to get into the health care profession,” he added. “I had no debt because I worked on an Indian reservation, and I loved that experience. I tell people that if you want to do primary care and you don’t mind working in an underserved area, your medical education will be free. So you should pursue it. Realize that you have this commitment to give back. You will be have financial freedom and will also have a really strong sense of goodwill for what you’ve done.”

And despite all of the hassles of private practice, Dr. Atkinson, a 1996 medical school graduate, offered no regrets of her own. “It’s still the best job in the world. I wouldn’t do anything else. I love what I do. I look forward to going to work. I make people better. People appreciate what I do. I make the world a better place.”

In this issue of *Vital Signs*, we also mourn the loss of our colleague, Dr. Richard V. Aghababian, who died Oct. 1 at his home after a long illness. Dick, who was our president from 2012 to 2013, served the MMS in countless capacities. He will be missed by all of us. Please read a tribute to him on page 6.

---

**VITAL SIGNS** is the member publication of the Massachusetts Medical Society.

EDITOR: Erica Noonan
STAFF WRITERS: Deb Beaujou-Volk, Vicki Ritterband

EDITORIAL STAFF: Charles Alagero, Office of General Counsel; Robyn Alie, Public Health; Lori DiChiara, Government Relations; Kerry Ann Hayon, Managed Care; Stephen Phelan, Membership; Cathy Salas, West Central Regional Office; Jessica Vautour, Physician Health Services

PRODUCTION AND DESIGN: Department of Premedia and Publishing Services; Department of Printing Services

PRESIDENT: Richard S. Pieters, M.D.
EXECUTIVE VICE PRESIDENT: Corinne Broderick
DIRECTOR OF COMMUNICATIONS: Frank Fortin

Vital Signs is published monthly, with combined issues for June/July/August and December/January, by the Massachusetts Medical Society, 860 Winter Street, Waltham, MA 02451-1411. Circulation: controlled to MMS members. Address changes to MMS Dept. of Membership Services. Editorial correspondence to MMS Dept. of Communications. Telephone: (781) 434-7110, toll-free outside Massachusetts: (800) 322-2303; fax: (781) 642-8976; email: vitalsigns@mms.org

Vital Signs lists external websites for information only. The MMS is not responsible for their content and does not recommend, endorse, or sponsor any product, service, advice, or point of view that may be offered. The MMS expressly disclaims all representations as to the accuracy or suitability for any purpose of the websites’ content.

©2014 Massachusetts Medical Society. All Rights Reserved.
Your Patients and Your Vendors: Keeping the Experience Positive

Candid Communication is Key

BY KERRY ANN HAYON
PPRC MANAGER

Patient experience, as defined by the Beryl Institute, is the sum of all interactions, shaped by an organization’s culture, that influence patient perceptions across the continuum of care. It is easy to consider the patient experience as those instances where the patient directly interacts with a physician, nurses and other staff. But what about all the other, less direct, interactions patients have — including those with your third-party vendors?

Recently, I spoke with a practice on the topic of improving its patient experience scores. The practice, about a year ago, started to be concerned about timely collections of the patient-owned components of their accounts. Their accounts receivable was on the rise and they decided to engage a collection agency to serve as an extension of the practice’s billing function.

After three months, there had been no improvement in the collection of past due balances and the practice started to get a lot of calls from confused patients, some of whom were upset and threatening to seek care elsewhere.

After some investigation, the practice found out that the process of collecting past due balances was not patient friendly; the company sent one letter and then started with collections-based phone calls and voice mails. These phone calls and voice mails provided no information on what the “collection” call was related to; the messaging was interpreted as threatening and accusatory and the patients were linking these negative interactions back to the practice.

Furthermore, patients reported that they were being treated rudely and told that key information, such as which physician and what service they owed a balance for, would not be provided unless they gave substantial personal information. Many patients weren’t comfortable sharing medical information (or general personal information). This situation negatively impacted the patient experiences for this practice.

It is important to note that collection agencies can be extremely helpful in reducing the uncollected patient owed components of aging accounts receivable, and most are reputable and professional organizations. But in this case, the process and messaging were faulty.

While just one specific story is highlighted here, general examples can also be seen in many other vendor-patient interactions. Consider the vendors that your practice engages to serve as an extension of your core business processes. Do you use a billing vendor? Do you use a scheduling service? What other agencies do you contract with?

Regardless of the scenario, when engaging external vendors who may directly interact with your patients there are a few key considerations to make sure that the services provided do not negatively impact your patient experience scores:

- **Meet with your vendors routinely.** Share feedback from your patients candidly. If you are unhappy with a vendor practice, point it out and suggest a solution. If you like something they are doing, let them know and have it be a routine practice for interacting with your patients.

- **Understand the process.** Understand what the vendor is doing, what methods they are employing and with what frequency they are using them. Request a process flow and make suggestions if you would like something handled differently.

- **Understand the messaging.** Put the time and effort in to understand the scripting that will be used and how information will be communicated with your patients, suggest edits, and make sure you are comfortable with the messaging approach.

- **Be sure your vendors are nice.** One does not have to be confrontational to get the job done. Make sure that your vendors are addressing the goal in a pleasant manner and that any scripted text is presenting things in a reasonable manner. In the example above slight script changes made the dialogue less confrontational.

- **Be sure to include a feedback loop in the process.** Consider implementing a feedback loop so that if the vendor feels that a patient is not responding adequately, there is a step that provides that feedback to the practice. Allowing the practice to engage or intervene in the communication with the patient can help in creating an overall positive outcome.

Hospital Medical Staff

*continued from page 1*

must also develop policies to address the concerns of the medical staff of each individual hospital.

2. CMS removed the requirement that a medical staff member must serve on the hospital system’s governing body.

Instead, the governing body is required only to consult with the leader of the medical staff periodically throughout the year — bi-annually at a minimum. This consultation must be a face-to-face or telephone/video meeting that is immediate and synchronous. This consultation must include a discussion of the quality of care delivered to the respective hospital’s patients.

3. Medical staff membership may include non-physicians. This is not a new rule, but a clarification of a 2012 rule that some critics found ambiguous. The new rule states that medical staff must consist of doctors of medicine and osteopathy, and may include podiatrists, optometrists, chiropractors, dentists, and other non-physician practitioners, if permitted by state law. The AMA argued that only M.D.s and D.O.s should be eligible for medical staff membership.

4. Outpatient services may be ordered by practitioners not on the medical staff. This must be approved by the medical staff and the hospital’s governing body, and permitted by state law.

Concerns

The AMA, the MMS, and 80 state and specialty medical societies asked CMS to delay the implementation of the rule until next year, but CMS refused. However, it suggested that it might give hospitals time to make their bylaws changes.

AMA Resources

The AMA has developed a checklist of specific issues that medical staff should consider. Visit www.massmed.org/hospitalstaffing to review the checklist.
MMS Publishes New Guide to Treating Victims of Human Trafficking

Health Consequences and the Physician’s Role

Many sex, labor, and organ trafficking survivors report having accessed medical care prior to and while they were actively victimized, highlighting a critical role physicians can play in identifying and assisting current victims of human trafficking, as well as those who may be at risk but who have not yet been actively trafficked.

“Victims of human trafficking tend to live under the tight control of traffickers and their associates, and thus have very limited access to the outside world,” explained Dr. Alpert. “Even living under coercive and often violent control, victims may still be able to access needed health care. Because physicians and other health care providers are generally regarded as trustworthy sources of help and support, the health care setting may represent a unique opportunity for identification and intervention.”

Victims of human trafficking often suffer specific physical and mental health effects, such as wounds, burns, fractures, overuse injuries, effects of environmental exposure, reproductive health issues, anxiety, depression, PTSD, panic attacks, and suicidal ideation — many of these can continue to affect their health long after the trafficking has ended.

Children who have been trafficked may experience delayed social, cognitive or physical development, and be at risk for vaccine-preventable diseases and other health problems.

The guidebook is designed to provide basic information about human trafficking and its health effects, and to offer guidance regarding efficient and trauma-sensitive techniques for identification, assessment and response. The guidebook also includes local, statewide and national resources both for patient referral and for ongoing education.

“The physician is often the first trusted person a victim may encounter. For this reason, it is critically important for physicians and other health care providers to know how to identify, assess, and assist those who may be at risk of being trafficked,” said Dr. Alpert. “Publication of this guidebook marks an important step in advancing global efforts directed toward intervention, and ultimately prevention, of human trafficking.”

Human Trafficking: Guidebook on Identification, Assessment and Response in the Health Care Setting, is available for reading or download from the MMS website at www.massmed.org/humantrafficking.

MMS Offers Online CME on Genetically Modified Foods

BY ROBYN ALIE
MMS PUBLIC HEALTH MANAGER

MMS recently launched online CME on genetically modified organisms, or GMOs. Testimony on the topic at the most recent HOD reflected physicians’ desire for reliable information, inspiring the Committee on Nutrition and Physical Activity to research literature on the topic. Deepa Arya, M.D., led the effort, writing a new paper, Genetically Modified Foods: Benefits and Risks, which is available on the MMS website at www.massmed.org/cme/gmo.

Q: Why did the Committee on Nutrition and Physical Activity decide to develop CME on GMOs?

A: There has been a lot of buzz in the media recently about GMOs. News stories discuss consumers’ concerns about having to bear the cost of GMO labeling, about GMOs creating “superweeds” (unapproved genetically modified wheat in two states). Additionally, anyone walking down a supermarket aisle now sees a plethora of foods labeled “non-GMO.” People on both sides of the issue speak very passionately about it and Americans are justifiably confused. Our piece about GMOs is very timely, in that respect.

Q: Why is this important?

A: As a nation, we have become more sedentary and our food has changed compared to our grandparents’ food. How much of the trend in obesity is due to sedentary habits and how much is due to a change in foods that we eat? Not only do we have a wide variety of packaged foods available to us but we have choices regarding organic vs. traditional and GMO vs. non-GMO foods. If the old adage, “you are what you eat” is true, then it behooves us to understand these issues pertaining to our food.

Q: Why is this issue controversial?

A: There is a significant amount of controversy around GMOs. Are GMO foods safe? Are they nutritionally equivalent? Will they cause allergies? Will they lead to genetic changes or increase risk of cancer? Should we be paying more money to buy non-GMO foods or are we just wasting our money? Should GMO foods be explicitly labeled as such? Are GMOs safe and any concerns not really valid? The Internet is flooded with all sorts of information; what should we believe?

Q: Could you share some highlights from your research?

A: Researching this topic was a fascinating journey. I gained significant insights about GMO foods, and the benefits and risks associated with them. Numerous agencies have conducted tests to assess safety and nutritional equivalence and the GMO foods are not released in the market until they are deemed safe. However, being safe is not the same as being risk-free. The adoption of GMO foods has been higher in the U.S. than in Europe. Some European countries have adopted a few GMO crops but overall the EU has moved gingerly on GMO adoption has a more precautionary approach.

Q: How can this help physicians?

A: Patients depend on their physicians for advice regarding the foods they should eat or avoid. I hope this article can provide physicians with unbiased information so that they can guide their patients and provide them with resources for additional information.
Overview of Advance Practice Nursing Regulatory Changes
Prescriptive Practice Requirements Loosened, Other Changes

The Board of Registration in Nursing recently adopted regulations governing Advanced Practice Nurses that had been pending for nearly a year.

The new APN regulations — which the MMS opposed and offered extensive testimony in hopes of modifying — outline an additional category of nurses eligible for expanded scope-of-care privileges, and significantly loosened practice guideline requirements based on longstanding statutes and practices. A summary of some relevant changes are as follows:

**Removal of Written Guidelines Requirement.** New regulations no longer require written guidelines for non-prescriptive practice. The guideline requirement in the prior regulations mandated a written consensus between the APN and the supervising physician on the scope of care, and required a description of the circumstances in which physician consultation or referral is required. Specific language requiring supervisors and nurses three months; the new regulations only call for a prescriptive practice review at a defined mechanism and time frame as indicated in the guidelines. The new regulations require guidelines to address tests and therapies only when appropriate. The underlying law makes no such limitation.

**Clinical Nurse Practitioners (CNPs) Can Provide Written Certifications for Marijuana.** The MMS opposed this language as directly contradictory to the state medical marijuana law. The rationale for adoption of this language is a statute, which precedes the marijuana referendum and allows CNPs to sign forms prevailing.

**Loosening of Prescriptive Practice Requirements.** The prior regulations required a review of prescriptive practices with a supervising physician at least every 0.2% over the same period. Overall, the Massachusetts medical practice and the high costs of maintaining a practice. Meanwhile, the rising costs of maintaining a practice. The prior regulations mandated a written consensus between the APN and the supervising physician on the scope of care, and required a description of the circumstances in which physician consultation or referral is required. Specific language requiring supervisors and nurses three months; the new regulations only call for a prescriptive practice review at a defined mechanism and time frame as indicated in the guidelines. The new regulations require guidelines to address tests and therapies only when appropriate. The underlying law makes no such limitation.

**Addition of Clinical Nurse Specialists as an Additional Category of Eligibility for Advanced Practice Nursing.** Clinical nurse specialists are recognized as a new category of APNs. No prescriptive authority has been created for this category.

**Prescribing Limits for Certified Registered Nurse Anesthetists (CRNAs).** CRNAs are limited to prescribing in the immediate perioperative period and non-prescribing CRNAs must work under orders of individuals with prescribing privileges.

**Changes Certified Nurse Midwives (CNMs).** The regulations recognize the changes in the law eliminating supervision of CNMs but do not fully honor requirements that CNMs practice in a health care setting or have provisions for consultation and collaboration spelled out in the 2012 statute giving them broader practice authority. The regulatory definition of health care setting includes an individual who bills insurance companies, for example.

The MMS continues to support physician-led teams as the best model for high-quality patient care. The impact of these regulatory changes on care delivery and quality remains to be seen; but remember the revised regulations do not mandate change from existing models of team-based care. Any changes in scope of care of your advanced practice nurses will be subject to the clinical team leader.

2014 MMS Physician Practice Environment Index Shows Less Favorable Environment in Mass. than Most of U.S.

Rising Costs, Housing Prices Responsible for Slow Growth in Mass.

The Index is a statistical indicator of nine factors that influence the practice climate for physicians: the number of applications to Massachusetts medical schools, the percentage of physicians over 55, the number of employment ads in the New England Journal of Medicine, median physician income, ratio of housing prices to median physician income, professional liability costs, physician cost of maintaining a practice, mean hours per week spent in patient care, and annual number of visits per emergency department.

This year’s index shows both positive and negative changes in the nine factors. Massachusetts gained more applicants to the state’s medical schools by 0.3%, but the state also experienced a rise in the percentage of Massachusetts physicians over 55 years of age by 0.7%. More visits last year to emergency departments — an increase of 0.5% — could signal an increased demand for services. But the small increase in Massachusetts’ physician income (0.6%) was not strong enough to overcome the high costs of housing and maintaining a practice.

As the economy has recovered over the last five years, housing values in the state have risen about 10%, as physician income has risen more slowly, at about 4.2%. While housing prices affect everyone, this indicator, along with the rising cost of operating a practice, provide a basis for evaluating the personal and professional costs of practicing medicine in Massachusetts.

Read more about the MMS Practice Environment Index and download a complete copy of results at www.massmed.org/mmsindex.
Physician Health Services (PHS) is adding new content to its Managing Workplace Conflict course. The new content, which is being designed to meet the needs of all physicians, will focus squarely on interactions between front-line physicians and medical leaders. The new, augmented two-day course will take place March 19–20, 2015, and will feature simulations, role-playing, and discussion of successes and failures drawn from the real world of current medical practice.

The physician leader who wrote the following article attended the course twice: the first time as a struggling front-line doctor, and the second time as a relatively new medical leader in a hospital. Because Physician Health Services is a confidential service, we have elected to maintain the anonymity of the physician who describes past involvement with PHS.

It was one of those late fall, gray afternoons with the threat of rain. I was sitting in my family room alone mulling over what had happened over the last several days. I was spent.

Earlier that day, an “urgent” meeting of my group had been called. When the announcement was made, I knew that this was not going to be easy. By the end of the meeting, I was an emotional pile of dung. I couldn’t speak, my eyes were red, and I was questioning my ability to function at work for the first time in my career.

Making the Call

Back in my family room, I picked up the phone. I half-dialed the number multiple times and then finally committed to the call. The voice on the other end of the line was calm, reassuring, and understanding. We talked for about 30 minutes. During that time, I relayed what had occurred and how I was feeling. We agreed that I was very vulnerable and in a difficult position. The director of Physician Health Services encouraged me to make use of its services, including an upcoming course, Managing Workplace Conflict. To this very day I don’t know if this was chance, fate, or divine intervention, but the course started in two days.

Learning New Tools

To say that my problems at work shook me up and caused me to withdraw is an understatement. Fortunately, I allowed the Managing Workplace Conflict lectures and role-plays to filter through the fog of my thought. I remember hearing of disruptive behavior and toxic interpersonal situations. Most importantly, I learned of resources to help and I started developing tools to cope with my problems. Overall, by the end of the two-day course I felt somewhat more emotionally stable. I had a plan and an initial spark of insight about things about me that I could improve upon.

I went back to work and re-established my confidence. I remained involved with PHS and pursued individual counseling; this gave me the solid foundation that I had been lacking. I devoured many of the readings suggested at the course, filling in knowledge gaps that were contributing to the problems I was having getting along with other members of my team.

Fast-forward about six years. My previous job, group, and hospital are behind me. I became a department chair, and subsequently a hospital CMO. At this juncture, physician stress and problematic behavior have a whole different meaning to me.

“I deal with problems by making use of tools that I learned to utilize at the course.”

Last year, I returned to the Managing Workplace Conflict course for a second time to reinforce and renew the lessons I had learned, and to reflect on them as a medical leader.

New Perspectives

With the perspectives I have gained, I believe that I have been able to enhance my understanding of the frustration and angst of my peers in a deeply personal way that allows me to be more helpful to others. I deal with problems by making use of tools that I learned to utilize at the course. Front-line physicians and medical leaders face similar challenges. We all want a harmonious work environment that allows us to deliver excellent patient care. We can all use help with managing the stresses and tensions that abound in today’s practice environment, and we can all use some objective help to improve our own performance. I try to make use of my own experience and learning in order to move our challenging work forward in a fashion that is win-win for everybody.

For more information, please contact Physician Health Services, Inc., at (781) 434-7404 or visit www.physicianhealth.org.

MMS Mourns Past President Richard V. Aghababian, M.D., 66, of Southborough

The MMS mourns the death of Past President Richard V. Aghababian, M.D., of Southborough.

Dr. Aghababian, 66, died at home Oct. 1 after a long illness. A graduate of Harvard College and the University of Massachusetts Medical School in Worcester, Dr. Aghababian was the founding chair of the Department of Emergency Medicine at the University of Massachusetts Memorial Medical Center and a past president of the American College of Emergency Physicians and the Massachusetts College of Emergency Physicians.

He served as president of the MMS from 2012–2013, after terms as president-elect, vice president, and secretary-treasurer. He was also a member of the Society’s Committees on Finance, Nominations, Physician Preparedness, Global Medicine, and Medical Education.

Dr. Aghababian received many honors and awards for his contributions to medicine and the community. In 2007, he was a recipient of the Annual Health Care Heroes Award from the Worcester Business Journal. He enjoyed traveling to Cape Cod and many other destinations around the world. He also had a passion for world history and enjoyed the study of rare coins.

Dr. Aghababian is survived by his wife of 42 years, Ann, and their two children. The family requests any memorial donations be directed to the Richard V. Aghababian, M.D., Fellowship at the UMass Memorial Foundation and mailed to UMass Medicine Development Office, 333 South Street, Shrewsbury, MA 01545.
2014 Interim Meeting of the MMS House of Delegates

Friday, December 5, 2014
MMS Headquarters
- Opening Session of House of Delegates
- Reference Committee Hearings
- Alliance Meeting and Luncheon
- Alliance Holiday Boutique
- Educational Programs:
  - Annual Oration: Medical Education Across the Continuum
  - Ethics Forum: Ethics and Pay for Performance
- Annual Research Poster Symposium

Saturday, December 6, 2014
Newton Marriott Hotel
- Second Session of House of Delegates
- Alliance Holiday Boutique

For more information and to pre-register visit www.massmed.org/interim2014.

Call for Nominations — MMS 2015 Annual Awards Program

The Massachusetts Medical Society and its Committee on Recognition Awards are currently seeking nominations for the 2015 Annual Awards Program. For more information regarding award criteria, application information, and submission deadlines, please visit www.massmed.org/awards2015 or call (800) 322-2303 ext. 7012.

- MMS Lifetime Achievement Award
- Special Award for Excellence in Medical Service
- Award for Distinguished Service to the Massachusetts Medical Society
- Grant V. Rodkey, MD, Award for Outstanding Contributions to Medical Education
- Henry Ingersoll Bowditch Award for Excellence in Public Health
- History Essay Award
- Information Technology in Medicine Award
- Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Award
- Medical Student Scholar Awards
- Men’s Health Award
- Reducing Health Disparities Award
- Senior Volunteer Physician of the Year Award
- Woman Physician Leadership Award
- Women’s Health Award
- Women’s Health Research Award

Member Renewal Statements Coming Soon

Your 2015 MMS membership renewal statement will contain two changes from previous years.

The billing address for MMS membership renewal statements has been changed to a processing office in Dallas, Texas. If you have any questions, contact MMS Member Processing at (800) 322-2303, ext. 7495, or mmsprocessing@mms.org.

Also, the MMS is no longer billing on behalf of the AMA. You will receive a statement from the AMA to renew your 2015 AMA membership. If you have questions, contact the AMA at (800) 262-3211, or visit www.ama-assn.org/go/join to join the AMA or renew your membership today.

ACROSS THE COMMONWEALTH

District News and Events

NORTHEAST REGION

Charles River — Resolution Review Meeting. Thurs., Nov. 20, 6:00 p.m. Location: MMS headquarters, Waltham. Executive Committee Meeting. Thurs., Dec. 4, 6:00 p.m. Location: Il Capriccio, Waltham.

Essex South/Essex North — Resolution Review Meeting. Wed., Nov. 19, 6:00 p.m. Location: Beverly Depot, Beverly.

Norfolk — Resolution Review Meeting. Tues., Nov. 18, 6:00 p.m. Location: MMS headquarters, Waltham.

Suffolk — Resolution Review Meeting. Tues., Nov. 18, 6:00 p.m. Location: East Garden Room, Massachusetts General Hospital, Boston.

For more information on these events, or if you have Northeast District news to contribute, please contact Michele Jussaume or Linda Howard, Northeast Regional Office at (800) 944-5562 or mjussaume@mms.org or lhoward@mms.org.

SOUTHEAST REGION

Plymouth/Bristol North — Joint Fall District Meeting. Thurs., Nov. 13, 6:00 p.m. Location: Stoneforge Tavern, Raynham.

Southeast Regional Caucus. Thurs., Nov. 20, 6:00 p.m. Location: LeBaron Country Club, Lakeville.

The delegates from Barnstable, Bristol North, Bristol South, Norfolk South, and Plymouth District Medical Societies will meet to review and discuss 2014 Interim Meeting resolutions.

For more information, or if you have Southeast District news to contribute, please contact Sheila Kozlowski, Southeast Regional Office at (800) 322-3301 or skozlowski@mms.org.

WEST CENTRAL REGION

Hampden — Fall District Meeting. Tues., Nov. 11, 6:30 p.m. Location: Log Cabin, Holyoke. Speaker: Sam Forman, M.D. Topic: Dr. Joseph Warren, Revolutionary War doctor and hero. For more information, contact Coni Fedora at (413) 736-0661 or hdfs@mmsmed.org.

Worcester — Fall District Meeting. Wed., Nov. 12, 5:30 p.m. Location: Beechwood Hotel, Worcester. The dinner meeting includes the A. Jane Fitzpatrick Community Service Award, the WDDS Career Achievement Award, and scholarship award presentations. A Night at the Movies — The Doctor. Thurs., Dec. 18, 5:30 p.m. Location: Washburn Hall, Mechanics Hall. Group discussion and holiday celebration to follow.

For more information, or if you have West Central news to contribute, please contact Cathy Salas, West Central Regional Office at (800) 522-3112 or csalas@mms.org.

The dinner meeting includes the A. Jane Fitzpatrick Community Service Award, the WDDS Career Achievement Award, and scholarship award presentations. A Night at the Movies — The Doctor. Thurs., Dec. 18, 5:30 p.m. Location: Washburn Hall, Mechanics Hall. Group discussion and holiday celebration to follow.

For more information, or if you have West Central news to contribute, please contact Cathy Salas, West Central Regional Office at (800) 522-3112 or csalas@mms.org.
IN THIS ISSUE
1 > Tales from Two Doctors
   > New Medicare Hospital Staffing Rules
2 > President’s Message: Doctors’ Tales: A Sense of Optimism
3 > Your Patients and Your Vendors: Keeping the Experience Positive
4 > New Guide on Human Trafficking
   > MMS Committee Publishes Paper on GMOs
5 > Advanced Practice Nursing Regulatory Changes
   > Mass. Physician Practice Environment Index
6 > One Physician’s Story: Managing Workplace Conflict
   > MMS Mourns Past President Richard V. Aghababian, M.D., 66
7 > MMS Interim Meeting Dec. 5–6
   > Across the Commonwealth

MMS AND JOINTLY PROVIDED CME ACTIVITIES

LIVE CME ACTIVITIES
Unless otherwise noted, event location is MMS headquarters, Waltham.

Managing Workplace Conflict
Thurs. and Fri. March 19-20, 2015

Public Health Leadership Forum
Wed., April 8, 2015

ONLINE CME ACTIVITIES
Go to www.massmed.org/cme
Risk Management CME
• NEW! Electronic Health Records Education (2 modules)
  – Module 1 - Guide to Health Information Technology
  – Module 2 - Making Meaningful Use Meaningful
• NEW! Genetically Modified Foods: Benefits and Risks
• NEW! Cause of Death Training for Medical Certificates

End-of-Life Care
• End-of-Life Care (3 modules)

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

Pain Management
• Principles of Palliative Care and Persistent Pain Management (5 modules)
• Opioid Prescribing, Risk Management of Opioid Therapy and the Opioid Abuse Epidemic (6 Modules)
• Legal Advisor: Identifying Potential Drug Dependence and Preventing Abuse
• Managing Risk When Prescribing Narcotic Painkillers for Patients

Other Risk Management CME
• Preventing Falls in Older Patients: A Provider Toolkit
• Guide to Accountable Care Organizations: What Physicians Need to Know
• HIPAA 2.0: What’s New in the New Rules?
• Cancer Screening Guidelines (3 modules)
• Impact of Effective Communication on Patients, Colleagues, and Metrics (2 modules)
• Effective Chart Review for Quality Improvement

Other CME
• Physician Employment Options in the Healthcare Environment
• Contracting with an ACO
• Finance 101 for Physicians and Practice Administrators
• A Roadmap to Bring an End to HIV and STDs in Massachusetts (3 modules)
• Using Data Wisely
• Just a Spoonful of Medicine Helps the Sugar Go Down: Improve Management of Type 2 Diabetes
• Weighing the Evidence on Obesity
• Aggregating the Evidence on Antplatelet Drugs: A Review of Recent Clinical Trials
• Acid Suppression Therapy: Neutralizing the Hype
• Preventing Overuse of Antipsychotic Drugs in Nursing Home Care

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