Physician Labor Markets Stay Tight Across Massachusetts

BY LEIF BRIERLEY

The 12th annual MMS Physician Workforce Study found that physician labor markets continued to be tight with four physician specialties — family medicine, internal medicine, gastroenterology, and neurology — experiencing significant shortages.

The study, released last month, showed — as in previous years — that physician shortages continue to influence labor market conditions statewide. Several regions of the state, including the Springfield and Pittsfield areas, had a majority of respondents reporting inadequate pools of physicians were available to fill needed positions.

The percent of physicians reporting that “the current pool of applicants is inadequate” and the percent of respondents “having difficulty filling vacancies” both increased several percentage points from 2012 to 2013. While the adequacy of the physician labor pool and the ease of physician recruitment have shown a dramatic improvement over the past five years, this year’s data broke from the previous five-year trend of improving conditions in terms of filling vacancies and adequacy of the applicant pool.

Other findings indicate some dissatisfaction with physician practice issues, but also indicate familiarity with several key health care reform initiatives.

Among practicing physicians, dissatisfaction with the time spent on administrative tasks versus time spent on patient care increased, with over half of physicians in 2013 either “very dissatisfied” or “dissatisfied” with the trade-off between patient care hours versus administrative tasks.

Massachusetts physicians also remained concerned about professional

A Vital Signs Interview with Mass. DPH Commissioner Cheryl Bartlett

BY ROBYN ALIE

The past year has been one of intense scrutiny for the state’s Department of Public Health.

The department underwent two high-profile scandals that surfaced last year: a DPH chemist was accused of falsifying results in drug cases; and a compounding pharmacy in Framingham falling under DPH’s oversight produced injectable steroids contaminated with fungal meningitis.

In June, Governor Deval Patrick appointed Cheryl Bartlett, RN, previously DPH deputy commissioner and director of the bureau of community health and prevention, to head up the department.

Commissioner Bartlett spoke with Vital Signs recently about the challenges she faces, and her priorities for the department.

“Part of my decision to take this job is that the staff wanted someone they felt comfortable and familiar with at a time when we have to rebuild image and goodwill on the public side,” said Bartlett. “Some of the things I like to do best is to either build something new or fix something broken.”

She said her varied background, including national certification in four nursing specialties — cardiovascular, epidemiology, surveillance and infection control, nephrology and dialysis, and HIV/AIDS — as well as her clinical experience, has prepared her well for her role as commissioner.

Living in a small, rural community and founding the Nantucket AIDS Network has also broadened her experience, she said. “I feel like in most of the things that come before me, I’ve done in practice,” said Commissioner Bartlett.

Bartlett is focusing on revitalizing the DPH, and rebuilding the infrastructure, following the erosion of
ACOs and Your Practice

As you can see from the cover story in this month’s Vital Signs, the MMS is pleased to present a new publication for physicians and their practice managers, the MMS Guide to Accountable Care Organizations: What Physicians Need to Know.

The 44-page publication provides detailed guidance on issues that physicians should consider, whether they are currently participating in an ACO, forming or joining an ACO, or entering into an integration agreement with another health care organization.

We all know that it is increasingly difficult for independent practices to compete effectively in today’s health care system. Many of us are reassessing our role in this rapidly evolving system.

Some of our colleagues want to become an employee of a larger health care organization. Others may want to retain some of their professional autonomy, while integrating some aspects of their practice with an ACO.

These are complex issues, and there is a great need for objective, third-party information. It’s our hope that this guide will help all our member physicians in the decision-making process.

The guide was written for the MMS and its physicians by Chris Collins, a principal at ECG Management Consultants of Boston, and J. Mark Waxman, a senior partner in the Boston office of the law firm of Foley & Lardner.

It will help you determine if your practice is ready to join an ACO, how you choose the right one, technology considerations, legal and governance issues, finances, and achieving clinical integration.

I invite you to download it at www.massmed.org/ACOguide.

Ronald W. Dunlap, M.D.

ACOs continued from page 1

For example, in addition to the ability to adapt to population-health team-based care, organizations need to have patience in waiting for the benefits of their efforts to pay off.

This point has been highlighted by the recent news that 9 of the 32 original Pioneer ACOs have abandoned the program, according to Dr. Spivak. “I think the reason [they dropped out] was clear: They didn’t understand how complicated it is to change physician and hospital behavior, and that to do it all in one year is virtually impossible,” she said. “It really takes three to five years to get to the point where you’re really going to reap the benefits of your work.”

Matthew R. Fisher, J.D., an associate with Worcester-based Merrick O’Connell Attorneys at Law, agreed. “You have to give it time to really see the sea change of culture be implemented. I wish everyone could have given it that time to sink in and see where it leads because it really is trial and error,” he said.

Organizations also need to recognize, according to Dr. Spivak, that “in order to make it work you need to spend money.” A great deal of that investment will go toward technological systems that allow practices to capture and use meaningful data.

In particular, robust information systems (e.g., EMR, secure messaging, patient portals, e-prescribing) are critical components of any clinical integration initiative to enable information exchange and data sharing, according to the MMS guide. In order to meet clinical integration standards, the guide continues, ACOs will often require a system through which physicians can efficiently exchange information regarding patient and practice experience; utilization claims information can be gathered, analyzed, and communicated; and physician compliance and performance can be measured in accordance with physician-authored benchmarks and standards.

Therefore, practices need to factor the lag time of cost savings into their plans for financing these systems, Dr. Spivak said.

The start-up capital required for ACO participation is another driving force of increased physician alignment with hospitals and larger groups, which have access to greater resources.

Choosing the Right Structure

However, finances are just one of many considerations for practices in choosing the right legal structure of their ACOs, which could include the following:

• Hospitals, physicians, and other providers under common control
• Providers affiliated through clinical and/or financial integration or a contracting network
• Large PCP practices or multispecialty physician practices
• PHOs that are clinically and/or financially integrated
• Medical foundations
• Staff model HMOs
• Contracted groups of suppliers
• Joint ventures of two or more of the above-listed entities

It’s also important to remember that only by participating in a formal ACO do practices have the legal flexibility to experiment with improving care through increased coordination, noted Robert P. Lombardi, J.D.,

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Important Updates to MassHealth

Has your practice started receiving MassHealth claim denials with a denial code of 1010?

If so, it may be because your service location is not properly registered. MassHealth is currently reviewing practice service locations for proper enrollment in order to be compliant with requirements outlined in the Affordable Care Act.

Just because you are receiving payment today for a service location does not mean it is properly registered. We recommend providers contact MassHealth Customer Service at (800) 841-2900 in order to confirm that all service locations are properly enrolled.

Starting October 1, 2013, MassHealth’s Primary Care Payment Reform Initiative is offering its new payment model to eligible primary care practices. These practices must seek Patient-Centered Medical Home certification by National Committee for Quality Assurance (NCQA) or, potentially, by the Health Policy Commission, once the Commission releases its criteria.

The revised payment model for these practices is comprised of the following three parts:

1. Comprehensive Primary Care Payment. A risk-adjusted capped payment for primary care services and a defined set of behavioral health services.

ACOs

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of Mirick O’Connell. “The [Stark and antikickback] law really stops you from doing many things unless you follow very specific rules or fall within very specific and very rigid exceptions,” he said. “What the ACO has initially provided is a loosening of these restrictions so we can see what collaboration does. It doesn’t change the restrictions and limitations for groups who want to do it outside of the formal ACO context,” he said.

Measuring Success

Despite the challenges, the physicians we spoke with described numerous benefits to becoming part of an ACO.

For example, although Atrius already has a 10-year history of working collaboratively with payers and other health care organizations, Lopez said that its formal ACO contracts, particularly as a Medicare Pioneer, have pushed it to build a structure that has engaged clinical leadership, care managers, and front-line clinicians in strategizing how to improve geriatric care in the ambulatory office, provide better care for high-risk patients in all settings, including skilled nursing facilities, VNAS, and at home.

Further, Dr. Lopez said, “although we were focused on this new population [Medicare PPO patients], many of the techniques, tools, processes, work flows, etc., that we’ve developed to better coordinate and manage the care of these patients, are ones that are applicable to other sets of patients such as our Medicare Advantage product and our commercial programs,” he said. “It’s had an impact across our whole system.”

Although Atrius did not achieve cost savings in its first year as a Pioneer ACO, Lopez said that it has indeed found success in achieving its triple aim to improve the health of the population, improve the health care experience, and reduce the per capita cost of care — “plus one,” which is to improve the engagement and satisfaction of its clinical and other staff. “Staff who are engaged, motivated, and energized are in a much better position to achieve the triple aim for our patients,” he said.

And better patient care — according to all of the experts Vital Signs spoke with — must be

More ACO Resources from MMS

Regional seminars
• Oct. 10: Peabody Marriott
• Oct. 29: Delaney House, Holyoke
• Nov. 5: Beechwood Hotel, Worcester

For more information or to RSVP, contact Lisa Smith at lsmith@mms.org.

Education programs
• Oct. 10: Physician Employment Options in the Health Care Environment
• Nov. 20: Data Analytics in the World of Accountable Care Organizations

Register at www.massmed.org/calendar

Other Web resources
• Accountable Care Solution Center: www.massmed.org/acsc
• Clinical and Financial Integration of Physician Practices: www.massmed.org/integration-seminar

The MMS Guide to Accountable Care Organizations can be downloaded by members at www.massmed.org/ACOguide.

3. Shared Savings Payment.

If the total cost of providing care for a patient population, including hospital and specialist services, is less than budgeted, the primary care practice will share in the savings. There is also an option for practices to engage in shared risk in exchange for a greater shared savings payout. In the shared risk scenario, the practice shares in the financial loss if the total cost is greater than budgeted.

Kerry Ann Hayon and Georgia Feuer

Physician Labor

continued from page 1

liability and liability costs, which continue to cause physicians to alter or limit the scope of their practice, impacting patient access to care.

However, physicians are becoming more familiar with the health care reform initiatives occurring both nationwide and locally. Overall, almost half of respondents were familiar with Chapter 224, the state cost containment law passed in August 2012.

More physicians indicated in 2013 they would be likely to participate in a voluntary global payment system than did in 2012, and 32.4% of physicians indicated their medical practice is currently reimbursed through global payments.

Finally, nearly three-quarters of physicians were “very familiar” or “somewhat familiar” with accountable care organizations, with 42% of respondents indicating their practice participated in this type of care delivery model.

The MMS, with the assistance of prominent labor economists, completed this year’s study, which builds upon the results of the previous 11 years of physician workforce studies. The most recent survey was mailed to 7,212 practicing Massachusetts physicians in January 2013. The recipients included both MMS members and nonmembers who were randomly selected from 18 specialties. Seven hundred and forty-eight physicians responded to the survey.

The full report can be downloaded at www.massmed.org/workforce2013.
Many Choices for Flu Vaccine
Physicians Key to Increasing Rates

Cheryl Bartlett continued from page 1

core functions due to budget cuts over the years. And, given the events of last year, she says, increasing efforts and resources for compliance and surveys.

Bartlett said she sees the DPH’s role as a partner with communities and key stakeholders, working in community coalitions, task forces, and partnerships. She wants to strengthen its community relationships and assess the most effective way to work with communities.

DPH now has responsibility for the administration of the Prevention and Wellness Trust Fund, established when Chapter 224, the health care cost containment law, passed in August 2012.

The fund is the first of its kind in the nation, and over the next four years will provide $60 million in grants to community, municipal, and regional agencies; aimed at reducing rates of expensive, preventable health conditions, and health disparities. Bartlett has also been focusing on the implementation of medical marijuana regulations, another new area of oversight for the department. As deputy commissioner, Bartlett oversaw the DPH workgroup charged with creating regulations.

“We want to do that well,” she said, to balance the needs of people who might benefit with community safety, while reducing diversion. She added that the public safety sector is engaged, and community leaders are comfortable in the way the department is ensuring their concerns are heard.

Bartlett noted that there will be an educational component to DPH’s medical marijuana efforts, to emphasize the harms associated with it, and an evaluative component looking at crime and recreational use, for example.

The Physician Role in Integrating Population Health and Clinical Care
Bartlett has created a new position, responsible for health information policy and informatics in order to provide data and technical assistance to help providers look at their patient panels as populations.

DPH has been working with community health centers on this population health approach, incorporating it into clinical care. “It’s key to better care coordination and reduced cost,” she said.

With a CMS grant, DPH is developing an e-referral system for coordinating care, similar to the state’s current Quitline referral system for tobacco cessation.

Physicians need to be part of shaping the future of health care, said Bartlett, who said she would like the physician voice to be heard more. Bartlett commended the highly skilled physicians at DPH who provide medical and public health insight, and created a medical advisory committee, which brings them together bi-monthly to learn from each other. “I’ve enjoyed working with physicians throughout my career,” said Bartlett. Her work “on the ground” helps her to be more practical, “a voice of reason” she said.

Reducing Health Disparities
A big charge of public health, said Bartlett, is health equity and health literacy, and reducing disparities. Bartlett is interested in looking at disparities through the lens of prostate cancer, and developing health messaging and supporting research in the state.

The U.S. Preventive Services Task Force recommendations regarding PSA tests have created some confusion; some primary care physicians have ignored the recommendations, others have stopped screening, said Bartlett, who serves on the Massachusetts Prostate Cancer Coalition and steers the statewide cancer advisory committee.

When asked, Bartlett said mental health is an area that DPH is just beginning to grapple with. Historically, programs have been segmented and siloed by disease, she said: DPH houses the Bureau of Substance Abuse Services, and the Department of Mental Health tends to handle the chronically and persistently mentally ill, but there hasn’t been a program for the mental health issues arising from stresses of daily life, depression, et cetera.

“There are behavioral changes that we want people to make that impact many diseases,” said Bartlett. “What role does mental health play in capacity to engage in behavior change? “We’re evolving that area,” Bartlett noted that the comorbidity of depression has been highlighted as a priority consideration for wellness fund applicants.

Bartlett says she is considering herself a collaborative leader. “I tend to get a lot of opinions to help me formulate my ideas and decisions.”
STATE UPDATE

Fall Legislative Session Kicks Off on Beacon Hill
Peer Review, Scope-of-Practice Are Main Issues

Looking forward to the fall legislative session, the MMS expects to be very involved with legislation before the Public Health Committee. House Bill 1924, “An Act Relative to Medical Peer Review,” would expand the statutory definition of medical peer review to include ACOs and other entities with legitimate interests in reviewing the quality of care provided to the patients of the Commonwealth.

Another legislative priority of the MMS is H. 1014, “An Act To Extend Patient Protections To Recipients Of MassHealth.” The bill would allow MassHealth recipients access to the new Office of Patient Protection, now housed within the Health Policy Commission. The bill is pending before the Health Care Financing Committee.

No hearing date has been announced for either bill.

The MMS will continue to focus on scope-of-practice bills. Legislation concerning optometry, podiatry, and advance practice nursing is pending before the Committee on Public Health.

Among the most concerning of these is a new bill, H. 2009, which grants independent practice to nurse anesthetists and nurse practitioners, including prescriptive authority and the ability to order and interpret tests. Expect hearings on H. 2009 and other scope-of-practice bills in late December.

Scope-of-practice has been a challenge in the regulatory arena as well. The state Nursing Board is poised to implement new regulations to allow advanced practice nurses to sign documents previously requiring a physician’s signature, and to allow nurse midwives independent practice.

These regulations are based on provisions included in the payment reform law passed last year and were opposed by the MMS.

Also expected in the fall is more news on leadership changes unfolding in the state senate.

Senate President Therese Murray, D-Plymouth, will reach the end of her term as senate president next year, and Senate Majority Leader Stanley Rosenberg, D-Amherst, appears to be the heir apparent at this stage of the process. No major leadership changes are expected in the House.

VS

— Ronna Wallace

FEDERAL UPDATE

DC Agenda Includes Medicare Reforms

The MMS plans to work actively on Capitol Hill this fall with our colleagues at the AMA, state medical societies, and national organizations to oppose the implementation of the Value-Based Modifier (VBM) in Medicare.

Included in the ACA over the strenuous objections of the MMS and the AMA, the modifier uses both unvetted cost and quality data to calculate payments, or penalties for physicians.

CMS continues to propose escalating the implementation of the VBM despite serious unresolved methodological issues and in advance of what is required by the law. The AMA has already succeeded in modifying some of the onerous requirements and we will continue to work with them to repeal, delay, or replace this provision.

At this time, however, the law stands. Physicians in groups of 100 or more as of October 15, 2013, who submit claims to Medicare under a single tax identification number will be subject to payment adjustments in 2015, based on their performance this year.

New Reporting Methods
By October 15, 2013, these groups need to choose one of three Physician Quality Reporting System (PQRS) reporting methods in order to avoid negative 1 percent value modifier adjustment in 2015. Groups of 100 or more can also voluntarily choose whether to participate in the quality tiering option, which compares their performance to the national average. Groups which perform above the average will receive a positive update, while those below will receive a negative.

As part of our advocacy on the Medicare Sustainable Growth Rate reform bill, we are urging Congress to coordinate any new quality and efficiency reporting programs with those that already exist and to repeal and rescind those which are ill-conceived and will undermine our overall goals of improving quality health care.

Included in the ACA over the strenuous objections of the MMS and the AMA, the modifier uses both unvetted cost and quality data to calculate payments, or penalties for physicians.

In the meantime, groups of 100 or more are encouraged to go the CMS website at www.cms.gov to learn more about the VBM program and how to register. The deadline is October 15, 2013.

SGR Reform — Fall Agenda
With Congress back from its summer recess in the fall, we expect focus on a SGR reform bill to intensify. With a bill unanimously reported out of one House Committee, we will now be focusing on the work of the House Ways and Means Committee, which shares jurisdiction over this issue, as well as the Senate Finance Committee. While we are further along in this process than ever before, we have very far to go before a final bill is passed and signed into law. Physicians, Medicare beneficiaries, persons with disabilities and military families, all of whom are impacted by this debate, are encouraged to check in with the MMS website, www.massmed.org, and weekly updates in Vital Signs This Week to learn the latest action and what you can do help advocate for the future of this critical health care program.

VS

— Alex Calcagno
Global and Community Health Conference for Medical and Dental Students
This full-day conference is designed for medical students and dental students from throughout New England who are interested in global and community health. Workshops, panels, and speakers will focus on subjects like finding volunteer opportunities, performing disaster relief both locally and abroad, administering refugee work, conducting research, designing sustainable projects, obtaining funding, and maintaining work/life balance. Speakers will include students, residents, fellows, and seasoned clinicians with a wealth of global and community service experience and interests.

Dr. Jim O’Connell, president of Boston Health Care for the Homeless, will be one of the keynote speakers for the program, and sessions will include a “couples” lunch panel on balancing family life with service, as well as an ethics panel, to discuss issues such as the responsibility of sustainability, what to do when cultural values challenge best health care practices, and how to weigh the benefits of service against the costs. Networking will also be a focus of the program.

Thanks, in part, to the generosity of medical and dental schools throughout New England that have contributed funds to help defray the cost of this program, the registration fee for this event is only $25.00 for all attendees, meals included. VS

For full details about this program, including an agenda, speaker information and how to register, go to www.massmed.org/globalhealth2013.

PHYSICIAN HEALTH MATTERS
Transforming Ourselves and Our Patients through Exercise
This month’s Vital Signs column is written by Eddie Phillips, M.D., the founder of the Institute of Lifestyle Medicine. Dr. Phillips’ column on prescribing exercise to patients also asks us to look at our own lives. When physicians are living a healthy lifestyle, they do the best job of addressing their patients’ lifestyle challenges. So as you step up your efforts to address inactivity in your patients, get moving and do what you can to take excellent care of yourself. You’ll feel better, and your effectiveness in reaching your patients will be enhanced.

— PHS Director Steve Adelman, M.D.

According to the Lancet’s special issue on physical inactivity published in July 2012 (in concert with the London Olympics) over 500,000 lives could be saved annually if rates of physical inactivity were reduced by just 10%. There is work to be done because only 40% of Americans comply with the Physical Activity Guidelines for Americans recommendation of 150 minutes per week of moderate intensity physical activity. Compliance rates drop to around 20% if we include the additional recommendation of twice weekly resistance training.

As physicians we have a unique opportunity to simply assess our patient’s exercise habits with a Physical Activity Vital Sign (PAVS). Two simple questions: “How many times per week are you physically active at a moderate intensity?” The answer is multiplied by the second question, “How long on average is each physical activity session?” This vital sign can be easily obtained and entered into the medical record by a medical assistant or nurse at the time other vital signs are obtained. This is done on a routine basis with millions of patients in Kaiser Permanente’s Southern California region.

The appropriate response to the PAVIS is then to briefly negotiate and write an exercise prescription for your patients to initiate, maintain, or increase their physical activity. This process can be automated as part of the end-of-visit care or delivered with a simple handwritten prescription and referral to an exercise program or professional who can then “fill the prescription.”

If you wonder whether you missed the class on exercise in medical school you are not alone. According to a 2002 survey, only 6% of U.S. medical schools had a required curriculum in exercise prescription. A recent 2013 survey of all U.K. medical schools reports only modest improvement.

However, the need to confidently and consistently prescribe exercise to our patients is gaining momentum as provisions of the Affordable Care Act begin to reward physicians for their patients’ health behaviors.

Help is on the way. The Institute of Lifestyle Medicine will present its annual Harvard Medical School CME course, “Active Lives: Transforming Ourselves and Our Patients,” on November 15 and 16 at the MMS headquarters in Waltham. Participants will learn how to effectively and efficiently write an exercise prescription and how to motivate you and your patients towards optimal levels of fitness.

— Eddie Phillips, M.D.

Interim Meeting Deadlines Fast Approaching
The 2013 Interim Meeting of the MMS House of Delegates will be held Friday and Saturday, December 6 and 7, at the MMS headquarters and the Newton Marriott Hotel.

The deadline for submitting resolutions is Tuesday, October 22.

Members may submit resolutions via email to resolutions@mms.org or at www.massmed.org/resolutions. Members will again have the option to post and share their draft resolutions online with colleagues for feedback prior to the deadline. Visit http://community.massmed.org/HOD/Interim2013/ for more details.

There are many events planned during the course of the two-day meeting, including the Eighth Annual Research Poster Symposium.

The symposium offers a venue for residents, fellows, and medical students to display their research and compete for cash prizes. The deadline for submission of abstracts is Monday, October 7. For detailed submission guidelines and more information, go to www.massmed.org/postersymposium or call Colleen Hennessey at (800) 322-2303, ext. 7315.

The deadline for hotel reservations at the Newton Marriott Hotel is Friday, November 8. To make reservations, please visit www.massmed.org/IM13reservations or call the hotel directly at (617) 969-1000.

Please visit www.massmed.org/interim2013 for more details about the 2013 Interim Meeting and to register online.
**VITAL SIGNS | OCTOBER 2013**

**INSIDE MMS**

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### 38th Annual Joseph Garland Lecture

**October 23 at HMS**

MMS invites you to a free event sponsored by the Boston Medical Library in the Francis A. Countway Library of Medicine:

**Adventures at the Intersection of Medical Journalism & Public Health**

The 38th Annual Joseph Garland Lecture, featuring speaker Lawrence K. Altman, M.D., columnist and Clinical Professor of Medicine, New York University.

**Wed. Oct. 23, 2013 5:30 to 6:30 p.m.**

Carl Walter Amphitheatre, TMEC Harvard Medical School
260 Longwood Ave., Boston
To RSVP, contact Roz Vogel at rvogel@hms.harvard.edu or call (617) 432-4807.

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### A Mentoring Night for Medical Students — The Future of Medicine

**Tuesday, October 15, 6:30 to 8:00 p.m.**

MMS headquarters, Waltham

On October 15, the Massachusetts Medical Society’s Committee on Women in Medicine will host the 7th annual mentoring night for medical students.

This event will allow medical students to hear experiences from physicians who encompass a broad range of backgrounds and work specialties.

Various career options in medicine, such as part-time careers, different work settings, and professional versus personal goals, will be highlighted.

This event creates a forum for physicians to share their insights on fulfilling career paths in the current practice environment with medical students.

A short meeting of the Medical Student Section will follow the program. To learn more, Erin Tally at (800) 322-2303, ext. 7413 or etally@mms.org.

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### Senior Physician of the Year Award

If you know a physician whose volunteer activities are worthy of recognition, nominate him or her for the 2014 MMS Senior Volunteer Physician of the Year Award. The recipient is selected by the Committee on Senior Volunteer Physicians. Criteria for nomination:

- MMS member, 60 years of age or older
- Commitment to volunteerism and dedication to sharing experience and medical expertise
- Only volunteer activity conducted in Massachusetts will be considered

Mail, fax, or email your nominations with a brief letter of explanation to:

Carolyn Maher
Massachusetts Medical Society
860 Waltham Street
Waltham, MA 02451-1411
email: cmaher@mms.org
tel: (800) 322-2303, ext. 7311
fax: (781) 893-2105

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**ACROSS THE COMMONWEALTH**

### District News and Events

**Barnstable — Legislative Breakfast.** Fri., Oct. 4, 7:30 to 9:00 a.m. Location: Faxon Conference Room, Falmouth Hospital, Falmouth. For more information, contact Southeast Regional Office.

**Franklin — Legislative Breakfast.** Fri., Oct. 4, 7:30 to 9:00 a.m. Location: Baystate Franklin Medical Center, Greenfield. For more information, contact West Central Regional Office.

**Hampshire/Franklin — Fall District Meeting.** Thurs., Oct. 24, 6:00 p.m. Location: Blue Heron, Sunderland. Speaker: MMS President Ronald Dunlap, M.D. Topic: Getting Ready: What Physicians Need to Know about ACOs and the New Practice Environment. For more information, contact West Central Regional Office.

**Middlesex West — Membership Meeting.** Wed., Oct. 16, 6:00 p.m. Location: Dolphin Seafood Restaurant, Natick. Speaker: David G. Gallo, Ph.D., director of special projects, Woods Hole Oceanographic Institution. Topic: Neptune’s Garden: A Voyage of Exploration in the Deep Undersea. For more information, contact the Northeast Regional Office.

**Norfolk District — Membership Meeting.** Thurs., Oct. 17, 6:00 p.m. Location: Sheraton Needham Hotel. Guest Speaker: Brian B. Hoffman, M.D., professor of Medicine, Harvard Medical School.

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### Networking Event for LGBT Health Care Providers

**Thursday, October 24 7:00 to 9:30 p.m.**

Club Café
209 Columbus Avenue, Boston, MA
To RSVP, contact Erin Tally at etally@mms.org or (781) 434-7413.

www.massmed.org/fallmixer

A prix fixe menu for $15 per person (includes tax and tips). Drinks will be extra.

Sponsored by the MMS Committee on Lesbian, Gay, Bisexual, and Transgender Matters.

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### 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.

Carlton M. Akins, M.D., 73; Dover, MA; Harvard Medical School, 1966; died June 9, 2013.

Francis J. Bednarek, M.D., 84; Wrentham, MA; Loyola University, 1970; died July 15, 2013.

S. Arthur Boruchoff, M.D., 91; Plymouth, MA; Cornell University Medical College, 1951; died May 28, 2013.

Emily T. Crane, M.D., 91; Plymouth, MA; Cornell University Medical College, 1945; died July 4, 2013.

Eli A. Etscovitz, M.D., 90; Dedham, MA; Tufts University School of Medicine, 1948; died July 10, 2013.

Edmund B. Hardin, M.D., 90; Kennebunk, ME; Lowna Linda University School of Medicine, 1945; June 28, 2012.

Eric H. Johnson, M.D., 73; Chestnut Hill, MA; Columbia University College of Physicians and Surgeons, 1965; died April 8, 2013.

Gary W. Kraus, M.D., 78; Mount Dora, FL; Case Western Reserve School of Medicine, 1961; died June 30, 2013.

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**www.massmed.org**
New MMS medical student members and leadership from Boston University gathered at a chapter welcome event at Arc Nightclub in Boston in August to learn about ways to get involved in organized medicine.