

VITAL SIGNS



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VOLUME 16, ISSUE 7, SEPTEMBER 2011

Social Media: Boon to Patients and the Profession

Asserting that social media can help physicians network, learn, and advance the interests of their profession, the MMS House of Delegates has adopted a broad set of guidelines for physicians' use of social media.

"Social media websites are influencing our patients," said Lloyd Fisher, M.D., chair of the MMS Communications Committee, which developed the guidelines. "Physicians have to learn how to use social media sites for professional purposes, just as we did with email a decade ago... Patients share information on Facebook and Twitter every day. If we're not participating in these conversations, we leave the field open for others to provide misinformation that could harm our patients."

Still, many physicians have been reluctant to engage in social media over concerns about professionalism. Dr. Fisher said, "These concerns are legitimate, but it's not very difficult to be professional in social media. For example, don't post anything that could identify a patient, and maintain boundaries between your professional and personal lives."

The MMS guidelines, available at www.massmed.org/socialmedia, provide practical suggestions on how to start using Facebook, Twitter, LinkedIn, and blogs to help build your practice, provide expert medical information, or simply demonstrate thought leadership.

"Patients want to hear from us, and social media can be a great place to speak with them," Dr. Fisher concluded. **VS**

Join the MMS LinkedIn Group

LinkedIn now hosts an online community solely for MMS members. Join the group to discuss controversies, pose questions to fellow physicians, and stay up to date on current topics. Visit www.massmed.org/linkedin to join for free.

EHR Proficiency Requirement No Cause for Panic Board of Medicine Director Sets Record Straight

BY DEBRA BEAULIEU

The mounting pressure to adopt health information technology (HIT) is causing anxiety for physicians across the country. In Massachusetts, an additional requirement for physicians to demonstrate proficiency in EHRs as a condition of licensure in 2015 has turned up the HIT heat to a near boil.

Even though the compliance deadline is still four years away, the MMS frequently receives calls and letters from physicians expressing confusion and worry about the new requirement. Fortunately, much of this angst is unfounded, according to MMS President and Worcester pediatrician Lynda Young, M.D. "Some of our members think that their practices will have to have established electronic medical records in order to be licensed, but that is not the case," she said. "Physicians have to have *proficiency*."

The board released specific licensing regulations on July 20. Following a six-week public comment period, a hearing on the proposed regulations is expected sometime in September.

No EHR Mandate

The actual language of the section in the legislation that sets forth the requirement is as follows:

The [Board of Registration in Medicine] shall require, as a standard of eligibility for licensure, that applicants show a predetermined level of competency in the use of computerized physician order entry, e-prescribing, electronic health records, and other forms of health information technology, as determined by the board.

Although an earlier version of the legislation included a mandate (which the MMS opposed) calling for statewide adoption of EHRs by 2015, the final law includes the proficiency requirement only. The purchase or adoption of an EHR is not necessary to meet the requirement.

Nonetheless, the very notion of linking HIT to physician licensure has spurred persistent confusion — and some outrage. Stancel Riley, M.D., executive director of the Massachusetts Board of Registration

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Public/Private Partnership Key to Statewide Health Information Exchange

BY LLOYD RESNICK

Health information exchange (HIE) — sharing health information between two entities — seems like a simple concept. With older methods, such as paper and fax, it *was* simple, but also slow and inefficient. When HIE entered the digital realm, as it did more than a decade ago primarily to streamline exchange of claim information between providers and payers, things got complicated.

Right now, there are several functioning "internal" or "private" HIEs in Massachusetts. The state's largest provider system, Partners HealthCare, has one, as do provider systems in central Massachusetts (SAFEHealth) and eastern Massachusetts (the New England Healthcare Exchange

Network, or NEHEN). Physicians and hospitals within these systems transmit patient health information back and forth electronically.

The lofty goal now is to somehow connect those private exchanges into a statewide "network of networks" so that, for example, patient information residing in the Partners system could be shared securely and rapidly with an ED physician at a hospital in the Berkshires.

Public/Private Partnership Necessary

The state Health Information Technology (HIT) Council, chaired by Health and Human Services Secretary JudyAnn Bigby, M.D., is responsible for that tall order of statewide linkage. The council, in turn, is receiving advice and

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Surprising Agreement

Lest we believe that health care reform is only about battles between stakeholders, allow me to cite several examples of surprising areas of agreement among the MMS and physician groups like ours and organizations representing hospitals and health plans.

First, I've heard more than once from the Massachusetts Association of Health Plans and the Massachusetts Hospital Association that global payments are not the only way to go and that there is room for other models, including episode-of-care and fee-for-service payments.

Let's remember that a comprehensive and realistic approach to payment reform and cost containment was produced *two years ago* by the Health Care Quality and Cost Council. The council's "Roadmap to Cost Containment" recognized the fact that such a complex problem requires a balanced solution, not one that's one-size-fits-all.

Another area of almost universal agreement is the crucial importance of primary care in any solution to our health care problem. Alas, there is less agreement on how to re-empower primary care, and this thorny issue often pits the interests of generalist physicians against those of specialists.

The simplest way around that conflict is to pump "new money" into the system, but with the current preoccupation with deficit reduction and cost containment, I don't foresee that happening soon.

However, the Health Care Quality and Cost Council is continuing to grapple with this dilemma, and be assured that the MMS will not endorse solutions that rob Peter to pay Paul.

— Lynda M. Young, M.D.

EHR Proficiency Requirement

continued from page 1

in Medicine, has criss-crossed the state to discuss the requirement. "Even though we continue to try to unconfuse and untangle everything," Dr. Riley explained, "urban myths about the law continue to proliferate. Our goal is that nobody loses their license because of this requirement. We're going to do everything possible to try to help everyone understand [what they need to do]."

Begin Preparing by 2013

Another common area of confusion surrounds how the 2015 compliance date might be affected by a physician's license renewal date. For example, some doctors scheduled to renew in 2016 have wondered whether they'll have to be in compliance as part of their 2014 renewal.

Dr. Riley said physicians don't have to prove their HIT proficiency before January 2015, regardless of where the renewal date falls within their two-year license cycle. However, the board cautions against waiting until the last minute to prepare for the requirement. "We think everybody should be starting by 2013 at the latest, so when they hit 2015 they'll have their stuff," Dr. Riley said.

Options for Demonstrating Proficiency

That "stuff," according to Dr. Riley, will include one of various forms of proof that a physician is competent in the required areas. Contrary to another misconception, the BRM will not be the arbiter of whether a physician is proficient. "We're just going to be the holders of certificates," Dr. Riley said. And physicians won't have to produce the certificate of compliance unless they are audited. The board intends to monitor compliance by extending its random audits of physician CME certificates beginning in 2015, Dr. Riley said.

Dr. Riley described a "proficiency pyramid" to illustrate methods the board anticipates physicians will use to achieve certification.

At the top of the pyramid will rest meaningful use, a challenging goal that those in pursuit of federal incentive dollars are working to achieve. "We think that few people are going to rely on proof of meaningful use to demonstrate proficiency," Dr. Riley said. "So we had to come up with ways other than that high bar."

The base of the pyramid, as the board envisions it, will include physicians who practice in group practices or hospitals that already use EHRs. "We think that the majority of these physicians are going to be

able to give us a letter from their hospital certifying that they are proficient in EHRs," Dr. Riley said.

MMS President Dr. Young falls into this category. Although her pediatric practice is now in the process of implementing an EHR, "We've had to do all of our charting and all of our dictating on electronic records belonging to the hospitals where we see patients," she said. "So, in fact, we are proficient. If physicians realize that that type of proficiency meets the requirement, it's not going to be such an onerous thing."

The middle of the pyramid will be filled by physicians who fulfill the competency requirement by obtaining three hours of specific CME programs. Eligible courses, which are under development by the MMS and other CME providers, will need to include four types of content to cover all of the bases set out in the law:

- E-prescribing
- Computerized physician order entry
- EHRs and how to use their various functions (e.g., obtaining lab and radiology reports, sending consults to other physicians)
- Other information technology

No Exceptions

The broad scope of compliance and education possibilities is intended to accommodate all physicians, including those who may not be directly involved in adopting EHRs or even seeing patients. The board believes that all physicians need to gain a basic knowledge of how these various systems work, partly because doctors may soon find themselves unable to obtain lab results any way other than electronically.

Consequently, the board does not plan to waive this requirement for any physician who has an active license. Rather, Dr. Riley said, the board is working hard to make the requirement as painless as possible. "We'll take everything except an excuse from your doctor," he joked, referring to the various acceptable proofs of proficiency.

An Ongoing Responsibility

Despite the relative ease with which physicians may certify that they are competent users of HIT, certification will not be a one-and-done requirement. Physicians will have to obtain new proof of proficiency every four years, but they won't have to submit a certificate unless they are audited. "We think it's reasonable to ask that this be an ongoing requirement because the technology changes so fast," Dr. Riley explained. **VS**

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

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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) 642-0976; email: vitalsigns@mms.org.

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Preparing for Accountable Care

While debate continues over the ACO model, accountable care approaches and risk-based contracting concepts in commercial, Medicare, and Medicaid environments are quickly coming on line. Consequently, physician practices and practice administrators will need to understand how to prepare for accountable care delivery models.

Before participating in new payment models or any accountable care model, take the following four preparatory steps:

- 1) **Recognize the need for transition.** Most practices interested in moving toward an ACO model will require a planned transition phase. Set up a timeline and prepare everyone for the coming changes.
- 2) **Know your practice.** Reacquaint yourself with your practice by truly understanding your patient population, the prevalent chronic diseases your practice treats, and the
- educational needs of your patients. Also, think about metrics: where do you stand, what are your cost drivers, and what are the opportunities for improvement? Identify the systems, processes, metrics, and resources that are necessary to move toward a risk-sharing model.
- 3) **Form partnerships.** As you refamiliarize yourself with your practice and analyze patient population, consider conducting a comprehensive relationship inventory by asking which provider relationships work well, whether or not the practice has a full complement of services, and if there's a need to develop any new relationships to fill identified gaps in services in preparation for moving toward an ACO model.
- 4) **Obtain infrastructure support and resources.** Help physicians, practice administrators, and other participating par-

ties gain a level of comfort with metrics reporting, communication between ACO participants, and disease-management processes. **VS**

— Kerry Ann Hayon

To learn more about how your practice can prepare to become an ACO, join us on September 13 for the CME program *A Path to Accountable Care Organizations: How Do We Get There from Here?* Visit www.massmed.org/aco2011 for more information.

New Accountable Care Solution Center Now on the Web

The MMS is pleased to announce its new set of services geared toward accountable care. The Accountable Care Solution Center (www.massmed.org/acsc) leverages the in-house expertise of the Society with industry experts to bring you tools, "how to" guides, and consulting services to address all your accountable care needs.

Tips on Writing Prescriptions for Over-the-Counter Drugs

As of January 1 this year, the Affordable Care Act (ACA) mandated that patients receive reimbursement for over-the-counter (OTC) medications from their flexible savings accounts or health reimbursement accounts only if accompanied by a prescription.

The AMA, the American College of Physicians, and the American Academy of Family Physicians are among several organizations lobbying Congress to repeal that component of the ACA, and two bills have been filed toward that end as well.

In the meantime, physicians should consider the following tips in an environment where patients may request prescriptions for OTC products.

- Consult your medical liability carrier to see what they suggest regarding prescribing of OTC products.
- Follow the same principles as when prescribing prescription products:
 1. Never write a prescription for something a patient has already purchased.
 2. Before writing a prescription, have the patient come in for an office visit if the patient hasn't been seen recently in your office or if you don't know what prescriptions the patient is currently taking or why the patient is requesting the prescription and you don't have enough information in the chart.
- Create office policy on how these requests will be handled and widely disseminate the information to staff and patients.
- Talk to patients about OTC drugs during office visits so they have an opportunity to ask questions. **VS**

— Kerry Ann Hayon

For more information regarding the Affordable Care Act and OTC drugs, go to www.healthcare.gov/law/provisions/fsa_hra.

LAW AND ETHICS

Risks and Benefits of Electronic Communication with Patients

As more and more physician offices adopt electronic health records (EHRs), physicians are increasingly communicating with their patients using secure messaging systems included with many of the EHR systems.

The option to communicate with patients electronically via secure messaging can greatly benefit physicians and patients. Utilizing this option can improve communications between visits, while creating accurate and instant documentation of such communications.

However, secure electronic messaging also presents liability risks for physicians. For example, as with telephone communications with patients, physicians must be careful when offering medical advice via electronic messaging if they haven't performed a physical examination or taken a history. Also, courts are likely to

consider electronic communications between physician and patient as sufficiently establishing the physician-patient relationship necessary to subject the physician



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to malpractice liability. This could potentially mean that failing to respond to an electronic message within a reasonable period of time could lead to claims that the standard of care was violated.

To assist physicians with electronic communications with patients, the AMA established policies on the use of such communications in clinical practice.

These policies state that electronic messaging "should not be used to establish a patient-physician relationship. Rather, email should supplement other, more personal, encounters."

The AMA further suggests establishing guidelines for appropriate use of electronic messaging that physicians can discuss with patients before engaging in electronic communications. These guidelines should include expected turnaround times and what kinds of medical issues (preferably non-urgent) are appropriate for electronic communications. **VS**

— William Frank, Esq.

The "Law and Ethics" column is provided for educational purposes and should not be construed as legal advice. Readers with specific legal questions should consult with a private attorney.

Foundation Grantee Improves Pediatric Care in Sierra Leone

Editor's note: Last year, the MMS and Alliance Charitable Foundation awarded a grant to Toyin Ajayi, M.D., a second-year resident in BU's Department of Family Medicine, to support physicians and study barriers to health care in Sierra Leone. Dr. Ajayi shares her experiences below.

In the 18 months since I left, there have been profound changes to the quality of health care that's delivered at Ola During Children's Hospital (ODCH), Sierra Leone's only tertiary pediatric hospital. Most importantly, user fees for the health care of pregnant and postpartum women and children 5 years of age and young-

er were eliminated. This is part of a wave of government recognition that even nominal health care fees can pose insurmountable barriers to poor families.

I spent about 20 percent of my time at ODCH engaged in direct patient care and teaching medical students. Sick children were often brought to the hospital in moribund condition; many had been ill for several days or even weeks prior to presentation. It was often frustrating to manage these patients, knowing that whatever I did would almost certainly be too little, too late.

Why were children from the surrounding slums — many within easy walking distance of the hospital — often brought in so sick that they were beyond saving? This was my research question. I conducted informal focus groups with *combras*, women who care for small children in a slum of Freetown, where sanitation is poor, few have access to nutritious food, and immunization rates are less than 50 percent. Here are some of the

answers that I uncovered:

- Families often opt for traditional healing (e.g., to treat seizures believed to be due to evil spells).
- Elders and family leaders help make health care decisions and take into account lost income from time spent not working and past negative hospital experiences.
- Many consider the hospital a death sentence.
- Many have experienced ill treatment, discrimination, and attempted bribery by hospital staff. Women are often afraid their children will be mistreated if they complain.

My colleagues and I brainstormed ways to address the need



Photo by Toyin Ajayi, M.D.

A mother with a sick child talks to a triage nurse at Ola During Children's Hospital in Sierra Leone.

for staff accountability, a community feedback mechanism, and an attitudinal change toward poor patients. Nurses now wear name tags, and a hospital liaison chosen by the community seeks local feedback and input.

Later this year I hope to conduct a formal study that will focus on developing culturally sensitive and plausible explanations for health and ill health, as well as compelling arguments to support the hospital as the preferential option for health care.

— Toyin Ajayi, M.D.

Grant Amount Increases: Deadline September 15

Earlier this year, the MMS and Alliance Charitable Foundation increased its international health studies (IHS) grant to \$2,000 per recipient. The deadline for 2011 IHS grant applications is September 15. For information, visit www.mmsfoundation.org.

Flu Vaccination Recommended despite Same Composition

The FDA-approved flu vaccine for the 2011–2012 season is composed of the same three strains found in last season's vaccine — an A/California/7/2009 (H1N1)-like virus, an A/Perth/16/2009 (H3N2)-like virus, and a B/Brisbane/60/2008-like virus. This is only the eighth time since 1969 that the flu vaccine composition has remained the same from one year to the next.

Despite the identical vaccine composition, the CDC still recommends annual flu vaccination because studies have shown that a person's protection against influenza viruses declines over the course of a year after vaccination. This decline in protection may be influenced by several factors, including a person's age and health status.

The CDC recommends vaccination against flu for everyone 6 months of age and older. Vaccination should begin as soon as the vaccine becomes available and continue throughout the flu season. **VS**

MMS Celebrates Anti-Tobacco Artists at State House



Photo by Jill Cricomes

The winners of this year's MMS Anti-Tobacco Poster Contest were honored at a ceremony at the State House in June. To view the winning poster entries, go to www.massmed.org/tobacco.

Front row (left to right): Caroline Shairs of Reading, Emily Gervais of Weymouth, Zachary Glass of Weymouth, Dylan Hall of Hampden, Jacob Bergeron of Spencer, and Dylan Modig of Leicester. Back row (left to right): Emai Lai of Andover, Shannah Lim of Malden, Skylar Hadad of Andover, Ysabella Santell-Wright of Lawrence, Sharon Bembery of East Walpole, MMS Alliance President Gladys Chan, MMS President Lynda Young, M.D., and Janet Kent, M.D., a member of the MMS Committee on Student Health and Sports Medicine. Kaiti Yoo of Northborough was not present.

STATE UPDATE

Payment Reform — Where Are We Now in Massachusetts?

With Gov. Patrick's health care cost containment bill still in play and more payment reform legislation expected to hit the Massachusetts senate floor as early as this month, legislators are struggling with where to draw the line between state regulation and allowing market forces to control costs. Calling for more incentives for people to stay well, Sen. Richard Moore (D-Uxbridge) and Rep. Steven Walsh (D-Lynn), Health Care Financing Committee co-chairs, plan to roll out the committee's own payment reform legislation.

The MMS remains concerned by the growing appetite for government regulation of health care prices at both state and federal levels. Rate setting wasn't very effective 20 years ago, and it's doubtful that it would be any more effective today. Moreover, players always find ways around price controls, leading to unintended and often unhealthy consequences.

Having been at the table of every commission, committee, public hearing, and meeting on cost containment over the past several years, the MMS feels the most comprehensive and realistic approach came two years ago with the Health Care Quality and Cost Council's "Roadmap to Cost Containment." It recommended a focused, multifaceted approach in recognition of the complexity of the problem. (To read the Roadmap in its entirety, go to www.mass.gov/healthcare.)

The MMS feels strongly that medical liability reform, primary care workforce development, consumer education and engagement, administrative simplification, antitrust protections for physicians, and expansion of interoperable medical records must also be part of a comprehensive approach to health care cost control. **VS**

—Ronna Wallace

Public/Private Partnership for HIE

continued from page 1

recommendations from the HIT-HIE Advisory Committee. The committee's multidisciplinary and high-powered makeup (it's chaired by John Halamka, M.D., CIO of Beth Israel Deaconess Medical Center) reflects "the need for a public/private partnership for this to be successful," said Richard Shoup, Ph.D., director of the Massachusetts eHealth institute (MeHI). MeHI received more than \$10 million from the federal government to get a statewide HIE underway and is facilitating the advisory committee's efforts.

Shoup predicted that "we'll have something [statewide] up and running by January 2013," but there's a lot to do between now and then — and not just from a technical connectivity perspective. Whether it's public or private, building, running, and maintaining a successful HIE takes money, trust from users in the exchange's accuracy and security, and its use has to blend easily into a physician's workflow, said Larry Garber, M.D., medical director of informatics at Fallon Clinic. Dr. Garber spearheaded SAFE-Health, a central Massachusetts HIE that connects Fallon Clinic with more than 20 practices and HealthAlliance Hospital in Leominster.

Ray Campbell, executive director and CEO of the Massachusetts Health Data Consortium, predicted it'll take 15 years to establish a mature, fully functioning HIE throughout Massachusetts. But smaller-scale interconnections between ambulatory practices and specialists or between community and tertiary hospitals are feasible in the next five years, he said. Campbell also mentioned another gap-filler: Direct, a low-cost, federally backed email technology that can provide physician-to-physician HIPPA-secure information exchange.

For its part, the MMS Committee on Information Technology (CIT) is evaluating emerging technologies to assess their usefulness to physicians. "We are particularly focusing on the small practice, so the emerging technology has to be affordable, easy to implement and use, and enhance workflow," said Eugenia Marcus, M.D., chair of the CIT. "The Direct project has the potential to fill the niche on the way to seamless health information exchange statewide and eventually nationwide."

How to Sustain HIEs

Campbell also stressed that the only way to sustain an HIE long term is with user willingness to pay for it — and that willingness comes only "if the system provides compelling business value by boosting practice revenue or lowering practice costs." Campbell said the successful private HIEs in Massachusetts have proven themselves in that regard and that the state should leverage those successes when planning a statewide network.

Rick Shoup agrees. "There's a rich legacy of capability on the advisory committee," he said. "Why reinvent the wheel? Some of the larger pri-

vate HIEs have already figured out a lot of the complexity. We're looking to leverage from and complement what they have done."

Leveraging the successes of the private exchanges will be important because, according to Campbell, the \$10 million of federal money to get the statewide HIE started represents "only about 10 or 15 percent of the funds that will be needed" to complete the job of creating a self-sustaining HIE in Massachusetts. Noting that many public HIE projects in other states had to shut down after startup funding ran out, Campbell said, "To be sustainable and self-supporting, a statewide HIE's entire operating budget would have to be provided wholly by user subscription fees."

Connecting the Independents

Sustainability is not the only challenge facing developers of a statewide HIE. "The million-dollar question is how to connect solo or small practices that are not affiliated with a larger provider system to the statewide HIE," said Dr. Garber. "I think it will be simpler to interconnect the existing HIEs like SAFEHealth and Partners to a statewide exchange than to connect small physician practices in certain parts of the state to the HIE," he said.

Noting that there are regions of Massachusetts that still don't have access to high-speed broadband service, Rick Shoup said that his institute, which is also the state's Regional Extension Center for helping practices achieve meaningful use of EHRs, is available to help small and unaffiliated practices prepare for connecting to the statewide exchange. "All of the approved EHR vendors and the implementation optimization organizations we've vetted have tailored their products and services to interoperate with the statewide HIE when it becomes available," said Shoup.

HIEs and Integrated Care

HIE development is running parallel to calls from many quarters for more coordinated care, health care cost containment, and payment reform. But experts differ in their opinions as to which will or should happen first. "I think HIE will be an enabler of integrated delivery," said Dr. Garber. Conversely, Ray Campbell sees the advent of alternative payment models and accountable care as a driver of HIE. "The fee-for-service model is the biggest impediment to HIE," Campbell said. But if accountable care takes hold and providers experience the quality and economic advantages of reducing avoidable rehospitalizations and not repeating tests, interest in HIEs will rise, he predicted.

Whatever the timeframe or the order of events in this all-out attempt to exchange health information electronically, Dr. Garber is sure of one thing: "I can't imagine practicing in a world prior to the HIE," he said. "I'm convinced that doctors will make the right decisions if we have the right information." **VS**

For regular updates on health information technology from the MMS, subscribe to the free, biweekly e-newsletter, *ARRA Advisor*, at www.massmed.org/newsletters.

Doctors Go “Back to School” in Dorchester

Last month, Mary Fleming, M.D., and Ashaunta Rachele, M.D. — residents from the Commonwealth Fund/Harvard University Fellowship in Minority Health Policy at Harvard School of Public Health — and Matthew Naunheim, a Harvard University medical student, visited the Henderson School in Dorchester as part of the MMS Committee on Diversity in Medicine’s Doctors Back-to-School program.

This program shows kids of all ages, especially those from underrepresented racial and ethnic groups, that medicine is an attainable career. The Henderson School serves children ranging from early childhood through grade 5 from diverse ethnic, linguistic, and ability backgrounds.

When asked, “What do doctors do?” Dr. Rachele told the students that doctors are like detectives — they use their five senses to find out what’s wrong with people who are sick. The physicians showed the children a chest x-ray, and Matt Naunheim talked to the kids about anatomy and then passed around a model of a human leg while discussing the various nerves and bones. The presentation ended with the doctors showing the kids how to measure a pulse and listen for a heartbeat with a stethoscope.

At the end, when Dr. Fleming asked the kids, “Who wants to be a doctor?” almost all of their small hands reached for the sky. **VS**



Photo by Therese Fitzgerald, Ph.D.

A fifth-grade student at the Henderson School listens to Dr. Fleming’s heartbeat.

PHYSICIAN HEALTH MATTERS

Medical Professionalism: Then and Now

Editor’s note: This is the first of a two-part series on medical professionalism. The second article will focus on the specific habits and skills of the medical professional.

“Professionalism” has meant many things over the years, from behaving with decorum to maintaining scientific knowledge. In medieval times, guilds evolved rules for their members that were often arcane and inaccessible to the people they served. In medicine, for example, exhortations for secrecy date back to the Hippocratics.

In nineteenth- and twentieth-century Western history, professional duty was closely tied to one’s social role or status in society, and social order was a primary goal. A prime literary example of the “social” view of professionalism is found in Kazuo Ishiguro’s novel *The Remains of the Day*. In this painful depiction of a domestic servant’s slavish devotion to duty, Stevens, the butler, proudly fulfills his duties to his employer while his father lies dying upstairs. As the novel explores the psychological and spiritual consequences of Stevens’ antiseptic view of professionalism, readers can easily see what Stevens can’t: by inhabiting his professional role to the fullest, he’s abandoned his father in his darkest hour.

In health care, the social movements of the past two centuries have drawn physicians and other health care professionals into child labor reform, public health initiatives, and the new field of occupational safety and health. As described by writers like John Steinbeck and Upton Sinclair, horrendous social conditions prompted physicians to join the front lines of social reform. Consequently, professionalism that had been neatly circumscribed by role, social class, or status began to change.

An even broader view of professionalism can be found in more recent work by commentators such as Matthew Wynia and his colleagues. Their

aspirational definition of professionalism in the November 18, 1999, issue of the *New England Journal of Medicine* set a standard that echoes throughout centuries of physicians’ involvement in their communities. Wynia et al. identified modern medical professionalism as much more than adherence to a guild’s list of accepted characteristics or behaviors. Rather, professionalism is about creating relationships that provide “a structurally stabilizing, morally protective force in society.”

Medical professionalism, they write, “protects not only vulnerable persons, but also vulnerable social values.”

This grounding of professionalism in moral relationships raises the bar for physicians seeking professional guidance that goes beyond a mere catalog of dos and don’ts. It puts the onus on physicians to seek out vulnerabilities and correct them, much like the AMA’s *Principles of Medical Ethics* encourages members to contribute to the improvement of the community, the betterment of public health, and the enhancement of access to medical care. It’s not enough for physicians to act as technicians; they must appreciate the full human context of their work.

This is a view of medical professionalism that includes protecting vulnerable populations and shows how far medicine has come since the days of guild secrets and social status. It’s a view that resonates increasingly with the demands of modern living on vulnerable patients and their families. **VS**

— Philip Candilis, M.D., D.F.A.P.A.
Associate Director, Physician Health Services, Inc.
Associate Professor of Psychiatry,
University of Massachusetts Medical School

Board of Medicine Now Auditing CME Credits

The Massachusetts Board of Registration in Medicine has begun conducting random audits of CME credits for physicians whose license renewal date is after July 1, 2011.

All physicians should maintain records of participation in Category 1 CME activities and be able to document the means by which they accumulated Category 2 credits.

Physicians who are selected for the CME audit will be notified by email and regular U.S. mail after their license has been renewed.

For more information about the board’s CME requirements, go to www.mass.gov/Eeohhs2/docs/borim/physicians/cme_booklet.pdf. **VS**

Poster Abstracts Due October 3

The Sixth Annual Research Poster Symposium, sponsored by the MMS Resident and Fellow and Medical Student Sections, will take place on Friday afternoon, December 2, at MMS headquarters, in conjunction with the MMS Interim Meeting.

The symposium offers a venue for residents, fellows, and medical students to display their research and compete for cash prizes in four categories: basic research, clinical research, clinical vignettes, and health policy/health education. The deadline for submission of abstracts is Monday, October 3.

For detailed submission guidelines and information, go to www.massmed.org/postersymposium or call Colleen Hennessey at (800) 322-2303, ext. 7315. **VS**

MMS Receives AAMSE Award for Group Enrollment

On July 23, the MMS received a Profiles of Excellence Award from the American Association of Medical Society Executives (AAMSE) for the Society's physician group-enrollment campaign.

Group enrollment is a paradigm shift for the MMS, which has traditionally focused on recruiting individuals. Recognizing the growing trend toward younger, hospital-employed physicians and the proliferation of large medical groups, the MMS increased its group-enrollment options and continued to attract individually practicing physicians by adopting strategies reflective of the



physician employment market and increasingly integrated practice structures.

With the introduction of group enrollment in 2009, groups of five or more responded enthusiastically. In 2010, the number of members in the MMS group-enrollment program doubled from 1,479 to 2,977. Internally, the number of dues invoices generated plunged from 2,977 individual invoices to 162 group invoices, and the Society saved thousands of dollars in renewal costs.

Group enrollment led to an overall increase in MMS membership, resulting in stronger advocacy and a significant increase in media exposure. **VS**

ACROSS THE COMMONWEALTH

District News and Events

Charles River — Executive Committee Meeting. Tues., Sept. 13, 6:00 p.m. Location: MMS headquarters, Waltham. **Delegates Meeting.** Tues., Sept. 20, 6:00 p.m. Location: MMS headquarters. **Fall Outing.** Sun., Sept. 18, 11:00 a.m. registration; 12:00 p.m. cookout. Location: Franklin Park Zoo, Boston. For more information, contact the Northeast Regional Office.

Franklin — Legislative Breakfast. Fri., Sept. 23, 7:30–9:00 a.m. Location: Baystate Franklin Medical Center, Conference Room A. For more information, contact the West Central Regional Office.

Middlesex — Fall Meeting. Sun., Sept. 18, 12:00–5:00 p.m. Location: Larz Anderson Auto Museum, Brookline. For more information, contact the Northeast Regional Office.

Middlesex North — Fall Outing. Wed., Sept. 7, 5:30 p.m. Location: Kimball Farms, Westford. For more information, contact the Northeast Regional Office.

Middlesex West — Executive Committee Meeting. Wed., Sept. 21, 6:00 p.m. Location: Dr. Jennifer Thulin's office, 67 Union St., #505, Natick.

Norfolk South — Executive Committee Meeting. Tues., Sept. 6, 6:30 p.m. Location: Abbey Park, Milton. For more information, contact the Southeast Regional Office.

Hampden — Fall Meeting. Tues., Sept. 27, 5:30 p.m. Location: Chez Josef Banquet House, Agawam. Topic: Sport Concussion Crisis. Speakers: Chris Nowinski, codirector of the Center of the Study of Traumatic Encephalopathy at BU School of Medicine, and Zachary Marowitz, Psy.D., neuropsychologist at Baystate Medical Center.

Jointly sponsored by the Holyoke Medical Center. CME credit available. Member: no charge; non-member: \$37.50. **Medical Legal Forum.** Tues., Jan. 24, 2012, 6:00 p.m. Location: Max's Tavern, Springfield. Topic: Ramifications of EMRs. For more information, contact Suzanne Skibinski at (413) 736-0661 or hdms@massmed.org.

Suffolk — Fall Reception for Students, Residents and Young Physicians. Thurs., Sept. 22, 7:00 p.m. Location: Clery's Restaurant, Dartmouth St., Boston.

Worcester — Individual Claims Consultations. Fri., Sept. 16, 9:00 a.m.–3:00 p.m. Location: Beechwood Hotel, Worcester. Problem-solving workshops to assist with medical claims processing. **20th Annual Women in Medicine Breakfast.** Fri., Sept. 30, 7:30 a.m. Location: Beechwood Hotel, Worcester. Speaker: Diane Pingeton, M.D., board-certified gynecologist and local Kundalini yoga and meditation teacher. For more information, contact Joyce Cariglia at (508) 753-1579 or wdms@massmed.org

Worcester North — Legislative Breakfast. Fri., Sept. 30, 7:30–9:00 a.m. Location: Four Points Sheraton, Leominster. For more information, contact the West Central Regional Office.

Statewide News and Events

Arts, History, Humanism and Culture Member Interest Network — Bird Banding. Sat., Oct. 1, 9:00 a.m.–12:00 p.m. Location: Joppa Flats Educational Center, Newburyport. For more information, contact the West Central Regional Office.

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

Interim Meeting Resolution Deadline: October 18

The 2011 Interim Meeting of the MMS House of Delegates will be held on Friday and Saturday, December 2 and 3, 2011.

The deadline for submitting resolutions is October 18. Members can submit resolutions online (preferred method) at www.massmed.org/resolutions, via email to resolutions@mms.org, or via fax to (781) 434-7589.

For the first time this year, resolution sponsors will have the opportunity to post draft resolutions online for feedback in advance of the deadline. More details about that will be coming soon.

The deadline for hotel reservations at the Westin Hotel is October 21. Please call the hotel directly at (781) 290-5600. **VS**

IN MEMORIAM

The following deaths of MMS members were reported to the Society in July and August 2011. We also note member deaths on the MMS website at www.massmed.org/memoriam.

George E. Altman, M.D., 89; Chestnut Hill, MA; Tufts University School of Medicine, 1946; died July 1, 2011. **Antonio S. Does, M.D.**, 79; Ludlow, MA; University of Lisbon, Portugal, 1956; died July 7, 2011. **Nelson F. Gauto, M.D.**, 46; Herrin, IL; National University of Asuncion, Paraguay, 1988; died April 29, 2011. **Joseph Hanelin, M.D.**, 93; Newton, MA; Wayne State University School of Medicine, 1939; date of death unknown. **Courtland L. Harlow Jr., M.D.**, 66; Kingston, MA; Boston University School of Medicine, 1971; died June 20, 2011. **Shawki G. Kanazi, M.D.**, 64; Easthampton, MA; American University of Beirut, Lebanon, 1973; died June 13, 2011. **Peter J. Mozden, M.D.**, 86; Newton, MA; Boston University School of Medicine, 1953; died January 4, 2011. **Myron K. Nobil, M.D.**, 82; La Jolla, CA; Yale University School of Medicine, 1947; died February 26, 2006. **Veronica A. Ravnikar, M.D.**, 61; South Weymouth, MA; SUNY-Syracuse Medical School, 1975; died July 15, 2011. **John B. Reardan, M.D.**, 85; Elk Grove, CA; Harvard Medical School, 1949; died May 10, 2011. **James E. Wood, M.D.**, 85; Bryn Mawr, PA; Harvard Medical School, 1949; died August 15, 2010. **Robert F. Wright, M.D.**, 89; Brockton, MA; Boston University School of Medicine, 1946; date of death unknown.

MMS President to Congress: No More Cuts



On July 14, MMS President Lynda Young, M.D., joined health care leaders and others from across Massachusetts to urge Congress to halt any further cuts to federal health care funding.

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MASSACHUSETTS
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VITALSIGNS

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Go to www.massmed.org/cme/events or call (800) 843-6356. Unless otherwise noted, event location is MMS headquarters, Waltham.

A Path to Accountable Care Organizations: How Do We Get There from Here?

Tues., Sept. 13, 8:00 a.m.–3:30 p.m.

Women's Leadership Forum: Graceful Self-Promotion

Sponsored by the MMS and its Committee on Women in Medicine. Fri., Sept. 23, 8:00–10:00 a.m.

The Electronic Medical Record's Impact on the Patient-Caregiver Relationship

Sponsored by the MMS in collaboration with CRICO/RMF and the Schwartz Center for Compassionate Healthcare. Tues., Sept. 20, 5:30–7:30 p.m. Inn at Longwood Medical, Boston.

CME Accreditation Orientation

Wed., Oct. 5, 8:00–11:45 a.m.

Caring for the Caregivers VIII: Meeting Changes and Challenges

Jointly Sponsored by the MMS and Physician Health Services, Inc. Fri., Oct. 14, 8:00 a.m.–5:00 p.m.

Federal Funding Opportunities

Jointly Sponsored by the MMS and Biomedical Science Careers Program. Thurs., Oct. 20, 3:00–7:00 p.m. Harvard Medical School, 25 Shattuck St., Boston.

Managing Workplace Conflict — Improving Personal Effectiveness

Jointly Sponsored by the MMS and Physician Health Services, Inc. Thurs., Nov. 17, 8:00 a.m.–4:00 p.m. and Fri., Nov. 18, 8:00 a.m.–3:00 p.m.

SAVE THE DATES

Monday, October 31

2011 State of the State's Health Care Forum

Friday, November 18

2011 Annual Directors of Medical Education
Conference

ONLINE CME ACTIVITIES

Go to www.massmed.org/cme.

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ext. 7306, or go to www.massmed.org/cmecenter.