BY DEBRA BEAULIEU-VOLK
VITAL SIGNS STAFF WRITER

The legalization of medical marijuana in Massachusetts is no longer just a ballot question; it’s reality. But physicians who are willing to certify patients for medical marijuana will find little research about its indications, contraindications, risks and benefits — especially in comparison to conventional pharmaceutical therapies.

For that reason, the MMS held a first-of-its kind CME event in June, in which more than 100 physicians gathered to learn how to navigate these new regulations using currently available medical science.

Throughout the half-day event, Medical Marijuana: Regulations, Responsibilities, and Communication, physician panelists presented various clinical scenarios in which marijuana certification could be considered.

Patients who had been using marijuana to alleviate disease symptoms before the passage of the referendum may use the law as an opportunity to become certified, legal users, noted Alan Ehrlich, M.D., an assistant professor of family medicine at University of Massachusetts Medical School.

“We as physicians are now the gatekeepers of deciding whether this is a legitimate use or not a legitimate use, but the agent is the same,” Ehrlich said.

Thus far, the research available on the medical effects of smoked cannabis is limited, but data does exist demonstrating some positive results. “When I went to medical school, this was information that was not available,” he noted. “The endocannabinoid system really has been elucidated over the last 20 years or so. What we’ve learned is that this is a system, just like the adrenorenergic system or the dopaminergic system.”

**Medical Marijuana Is Not a First-Line Therapy**

Nonetheless, in order for a patient to be eligible for medical marijuana certification in Massachusetts, he or she must suffer from a debilitating medical condition, such as cancer, glaucoma, HIV, or other diseases that can cause weakness, intractable pain, or otherwise substantially limit a patient’s quality of life.

During the presentations, panelists frequently cited multiple sclerosis (MS), which is a listed certifiable disease afflicting most of its sufferers in their 20s and 30s, as an example illustrating physicians’ complex decision-making process of whether to certify.

Patients with advanced practice nurses to order and interpret tests, order treatment and therapeutics, and prescribe medications independently, in any setting, with any patient and therapeutics, and prescriber independent practice authority.

The MMS and interpret tests, order treatment and therapeutics, and prescribe medications independently, in any setting, with any patient and therapeutics, and prescriber independent practice authority.

The MMS had strongly opposed the practice expansion measure, arguing it was contrary to an optimal physician-led, team-based health care delivery model and was a possible threat to patient safety.

continued on page 2

**Statehouse Update:**

**Practice Expansion for APNs Rejected**

BY RONNA WALLACE
MMS LEGISLATIVE CONSULTANT

Massachusetts legislators have rejected proposed legislation that would have allowed nurse practitioners and nurse anesthetists to practice independently.

The move last month on Beacon Hill by a joint conference committee scuttled the proposal that would have allowed advanced practice nurses to order

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Medical Marijuana
continued from page 1

treatments to manage their disease before turning to marijuana to help manage symptoms of their disease, or in some cases side effects of other treatments.

Risk Is Relative

When it comes to marijuana, people often hold biases at extreme ends of a spectrum, noted Kevin P. Hill, M.D., MHS, director of Substance Abuse Consultation Service, Division of Alcohol and Drug Abuse at McLean Hospital and an assistant professor of psychiatry at Harvard Medical School. “We have people who believe that any marijuana use will lead you on the road to ruin. We have people who believe that it’s harmless. The answer is really somewhere in the middle,” according to Dr. Hill.

Nonetheless, Hill presented several risks about marijuana that he recommended physicians keep in mind:

1 Addiction. An estimated 9 percent of adults who use marijuana become addicted, which translates to about 2.7 million people out of current users.

2 Cognitive decline. “Imaging studies show that people using marijuana regularly are working at a much higher pace, recruiting different parts of the brain, to get the same amount of work done as someone who is not using it,” Dr. Hill said. Research has shown that regular marijuana users may experience up to an eight-point decline in IQ, he added.

3 Worsening anxiety. “A lot of people talk about using marijuana to treat their anxiety,” Dr. Hill said. “While acutely your anxiety level is going to go down [with marijuana], ultimately you’re raising your baseline anxiety level.”

4 Psychosis. “We have strong data showing that if you have a family history or risk [of schizophrenia or other psychiatric disorders] that you increase the likelihood that you’re going to express that risk if you use marijuana,” he said.

5 Withdrawal. People who use marijuana daily and stop abruptly often experience withdrawal symptoms similar to nicotine withdrawal, Dr. Hill said.

Advertising Space Now Available on MMS Website and e-Newsletters

The MMS is now offering organizations the opportunity to increase brand awareness and visibility to physicians and the general public through advertising space on the MMS website and several MMS email newsletters.

Website advertising space is available at the top of the right column on the home page and all internal pages of the site, except for continuing medical education courses.

Email newsletter advertising space is available in the weekly email newsletters Vital Signs This Week and Continuing Medical Education Update, as well as the daily e-newsletter MMS MediaWatch.

To learn more about the audience for these communications vehicles, as well as rates and ad specifications, download the MMS media kit at www.massmed.org/advertising.

Battling Opiate Abuse with New Tools

You can’t miss the disturbing headlines about the nation’s opiate abuse epidemic. Even in Massachusetts, which has much lower opioid prescription rates than many other states, an estimated 900 residents have died from opiate overdoses in the past two years.

The MMS has offered its support to a number of public and private initiatives to reduce opiate abuse and save lives. We are also advocating strongly for improvements to the state’s Prescription Monitoring Program, a program MMS helped to establish more than 20 years ago.

We believe all prescribers should have access to up-to-the-minute data on individual patients. The PMP should be a real-time tool that physicians can seamlessly incorporate into clinical decision-making, not an obstacle or hindrance.

Physicians must be vigilant in reminding lawmakers and the public that patients who experience severe pain need proper treatment and should be able to get relief. We must also educate patients and families about the importance of securing these medications so they do not fall into the wrong hands. Payers must ensure that the resources required for a more comprehensive approach to pain management are readily available, including options such as physical therapy, acupuncture and cognitive behavioral therapy.

We feel that a re-energized PMP medical review board would give an added boost to the effort. The board should be charged with determining patterns of abuse and proposing needed interventions.

It’s time to move forward, and physicians stand ready to help.

— Richard S. Pieters, M.D.
The Retail Clinic Movement: A Disruptive Threat or Opportunity for Physician Practices?

**BY TALIA GOLDSMITH**
PPRC ADVISOR

Retail clinics offering immunizations and treatment of common respiratory illnesses, skin conditions, and ear, nose, and throat problems are increasing in popularity. These clinics offer consumers health care services, sometimes in 15 minutes or less, at a convenient location, such as big-box discount stores, grocery stores, and pharmacies. More recently, the clinics — typically staffed by nurse practitioners (NPs) and physician assistants (PAs) — have expanded into the business of treating chronic conditions such as asthma, diabetes, and high cholesterol. Recent changes in Massachusetts law eliminated many public protections in regulations of these limited service clinics, but does prohibit the clinics from serving as primary care providers. The retail clinic concept trends away from the conventional model of primary care delivery and creates challenges for primary care providers, such as a decrease in patient volume and proper tracking of patient care.

**What Can Physicians Do?**

**>> Determine Why Your Patients Are Using Retail Clinics Rather than Coming into the Office.**

Many organizations have started to analyze their patients’ reasons for seeking care at a retail clinic. One physician practice recently indicated that upon informal surveying patients, they found that their patients required access during nights and weekends. The practice has since started focusing on putting a plan in place in order to address patient concerns around access, with a focus on the particular issues that historically have attracted patients to seek retail clinics over their doctor’s office. Most notably, practices are now offering same-day appointments, extended office hours, or walk-in hours to treat certain medical conditions. When considering expanding access, it is advisable to review utilization and call volume — strategically expanding access can allow a practice to meet the need while minimizing the financial impact. A little research and process enhancement can go a long way. Keeping an eye on seasonality is also advisable.

**>> Track Retail Clinic Activity.**

Focus on incorporating a question like “Have you visited a retail clinic recently” into the check-in process. You may be unaware that a patient received care and may not know what course of treatment was recommended. This is another opportunity to ask the patient why they chose to seek care in a retail clinic. Practices should consider tracking how many patients visit retail clinics and follow up with them to find out how to better serve them. You may find that when patients are educated, they may be more likely to call your office next time around.

**>> Pay Attention to Emerging Care Models.**

Staying on top of the current trends in health care is important as the industry continues to evolve at such a rapid pace. Pay close attention to changes in payer policies, regulatory requirements, and other changes that may impact the way you conduct business.

Contact the Physician Practice Resource Center (PPRC) today to learn what we can do to help you stay on top of the most current health care trends. Visit us online at www.massmed.org/pprc.

**Retail Clinics: Physicians Eye Swift Growth in Massachusetts with Concern**

**BY LINDSAY GARITO**
MMS HEALTH POLICY ANALYST

Although patients clearly find retail clinics convenient for acute care and less expensive than an emergency room visit, many physicians have concerns about the consequences of seeking care at limit-based clinics. The most frequently cited concerns relate to coordination and fragmentation of care, as patients may interpret limited-service clinics as a replacement for the relationship with their primary care provider.

Retail clinics have been present in the Massachusetts health care landscape since 2008 and there are presently more than 30 clinics statewide. Massachusetts was the first state to identify the need to regulate the presence of these clinics and how they would impact patient care. The Massachusetts Public Health Council issued guidelines for the operation and scope of such clinics, including regulations on what age groups can be treated, what conditions can be treated, and how to encourage interaction between the patient’s primary care provider and ensure continuity of care. In 2012, the regulations were updated to expand the definition of limited services and to give nurse practitioners the ability to treat all conditions that are within their scope of practice and training.

Although patients may view limited-service clinics as a convenient option when their primary care physician is unavailable, the MMS and other organizations continue to emphasize coordination of care and relationship-building to ensure optimal care.

**The Massachusetts Medical Society’s First Annual PPRC Talks: Topics in Practice Management**

**September 9th, 8 a.m.–noon**
MMS Headquarters, Waltham

**Featured Speakers**

- **Social Media**
  Jennifer Joe, MD

- **Practice Compliance**
  Jeff Louglin, MHA

- **Retail Clinics**
  Ateev Mehrotra, MD

- **Patient-Centered Medical Homes**
  Judith Steinberg, MD

**What will it take to prepare your practice for the future?**

What you need to know

Join us for this FREE program!

Register now at www.massmed.org/pprctalks
Physicians Now Need State-Approved Concussion Training to Clear Student-Athletes

BY ROBYN ALIE
MMS PUBLIC HEALTH MANAGER

State regulations now require physicians and others who provide medical clearance for students participating in Massachusetts Interscholastic Athletic Association (MIAA) activities to verify that they have received state-approved training in traumatic head injury assessment and management, or equivalent continuing education or licensure training.

Before the season starts, these students, including those participating in sports, cheerleading, and marching band, must receive medical clearance that documents any past head injuries.

Medical clearance must also be provided after any head injuries sustained during the season, whether or not the injury was sustained during an MIAA activity. Medical clearance must be documented on state forms, which can be found on the Massachusetts DPH website.

Sports are a leading cause of traumatic brain injury (TBI), along with falls, motor vehicle accidents, unintentional blows, and assaults. The CDC puts the number of sports and recreation-related TBIs occurring in the United States each year between 1.6 and 3.8 million. Most of these are mild cases and not treated in a hospital.

Duration of TBI symptoms is highly variable and may last days, weeks, months, or in some cases, even longer. Research shows that recovery time may be longer for children and adolescents.

State-approved trainings and medical clearance forms, along with other related resources can be found on mass.gov/dph/sportsconcussion.

An IHS Grantee Reflects on Medicine in Northern Ghana

Catherine Mygatt, M.D., a second-year resident at Lawrence Family Medicine was awarded a 2013 International Health Studies grant to work with patients in northern Ghana by the MMS and Alliance Charitable Foundation. This is her story:


I was prepared for our trip to be hard — I knew I would see death. They told me I would work harder than I had ever worked in my life, and yet my actual experience far exceeded anything I was prepared for. My three weeks in Ghana were the richest, most intense, best learning I have ever experienced. There are no work-hour restrictions in Ghana, and the work never ends. You spend any energy you have at the hospital. There are patients to round on, lacerations to sew, babies to deliver, and medical mysteries to solve. You don’t ever want to leave; otherwise you’re sure to miss something.

With such need, you can’t help but gain experience. There are no specialists to call. When faced with a clinical question, you use the training you have and the books at your fingertips to do your best, which goes quite far. When you can’t get a CBC after noon, you learn to look in people’s eyes, literally, and approximate their hematocrit. You learn your physical exam: how to feel a liver and a spleen, for example, first because it’s actually palpable, second because it’s an important part of directing your limited syndromic differential, and third because your exam is the most reliable metric you have.

I’m often caught comparing my work here as a resident with my work there as a doctor. My life as a resident is so focused on providing care to relieve suffering and to my patients can easily be obscured. In this environment, my responsibility to the profession and to my patients can easily be obscured.

Medicine, in its purest form, is providing care to relieve suffering. Three weeks in Ghana brought this responsibility back into focus for me. When medical resources are minimal, and the frivolity of Western medical systems is stripped away, I find myself humbled by how I’ve yet to learn and the hard work that lies ahead. I’m empowered by my experience and determined to use and honor all I’ve learned as a healer thus far.

The deadline for the MMS and Alliance Charitable Foundation’s 2014 International Health Studies grant is September 15, 2014. For more information and to apply, visit www.mmsfoundation.org.

André Guay, M.D., Receives MMS Men’s Health Award

André Guay, M.D., director of the Center for Sexual Function at Lahey Medical Center in Peabody was recently awarded the 2014 MMS Men’s Health Award.

"Dr. Guay has devoted a significant part of his career to advancing the field of men’s health and has been a pioneer and leader in the field of men’s sexual dysfunction," said Bruce Campbell, M.D., chair of the MMS Committee on Men’s Health.

The award was given as part of the Society’s 12th annual Men’s Health Symposium, where Dr. Guay presented on the topics of testosterone and cardiovascular disease.

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Patients wait on a clinic day at Baptist Medical Centre in Nalerigu, Ghana.

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André Guay, M.D.
Closing or Leaving Your Medical Practice

BY WILLIAM FRANK, ESQ
MMS ASSOCIATE COUNSEL

The closing of or departure from a medical practice requires careful attention on the part of the physician. If mishandled, these events can significantly disrupt continuity of care and endanger patients. Once a physician-patient relationship has been established, physicians have a legal and ethical duty to provide continuity of health care. Although there are no specific Massachusetts statutes or regulations on the matter, the premature or improper termination of medical treatment is often the subject of a legal cause of action known as abandonment. A physician may be civilly liable for abandonment as a result of his or her unilateral termination of a physician-patient relationship without proper notice to the patient when there is still the necessity of continuing medical attention.

Patients should therefore be given reasonable advance notice of a physician’s departure to allow other medical care to be secured. The amount of notice required depends on factors such as the type of practice, the health status of the patients in the practice, and whether there are other physicians in the area that can continue the care of the patients subject, but to avoid a claim of abandonment, the physician must provide some form of effective notice of his or her departure from practice. Such notice can be accomplished by sending a form letter or postcard to the patients and by placing an advertisement for a period in a local newspaper. Like the notice period, the method of notice may be tailored to the patient population. For example, high-risk patients (e.g., post-op patients or those currently being followed for serious or chronic conditions) may be more likely to experience adverse outcomes and allege abandonment if their physician is unavailable for ongoing care. Accordingly, physicians may consider sending these patients a letter by certified mail, with return receipt requested.

These letters and the advertisement should provide patients with general information about the physician’s departure/practice closing, including when the practice the physician is leaving closes and how copies of medical records can be obtained by the patient or transferred to another physician. If the departing physician will no longer be available for ongoing care elsewhere, the letter should inform patients on how to find another physician to continue their care. To accomplish this, it is appropriate to refer patients to other physicians, to their health plan, or to a referral service.

More information on closing a practice is available online at www.massmed.org/legalresources. 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.

FEDERAL UPDATE

Hoping for Revived SGR Reform; Progress on Federal Opioid Addiction Bills

BY ALEX CALCAGNO
MMS DIRECTOR OF FEDERAL RELATIONS

After the disappointing failure of the Medicare Sustainable Growth Rate reform bill earlier this spring, efforts are underway to resurrect consideration of permanent reform during the so-called “lame duck” session. The hope is that some members who will not be returning to Congress in January 2015 will be willing to vote on permanent SGR reform, even if they did not support it previously. The question of funding for SGR reform has yet to be solved, but Congress seems to understand the clear financial folly of doing nothing. Stay tuned.

The TREAT Act and CRIB Act

The MMS has been working closely with members of the Massachusetts Congressional delegation on two bills designed to address problems caused by the surge in opioid addictions. The TREAT Act introduced by U.S. Sen. Edward J. Markey would increase the number of these patients qualified providers could treat with opioid medications in approved settings. U.S. Rep. Katherine Clarke recently introduced the CRIB Act, which will direct the U.S. Department of Health and Human Services to gather more data on the number of infants born with neonatal abstinence syndrome and to provide physicians with the best practices for treatment.

Finally, the MMS and AMA have been very involved with a number of regulations emanating from the Centers for Medicare and Medicaid Services, including those impacting the Sunshine Act, medical staff in large health care systems, and to provide physicians with the best practices for treatment. The law mandates patient-nurse ratios of one nurse to one patient, or one nurse to two patients, “depending on the stability of the patient as assessed by the acuity tool and by the staff nurses in the unit, including the nurse manager or the nurse manager’s designee when needed to resolve a disagreement.”
By Steve Adelman, M.D.
PHS DirectOr

Attorneys who help physicians with employment and licensure issues are used to hearing doctors utter those words. The recreational use of psychoactive substances such as alcohol and marijuana can definitely be a source of trouble for practicing physicians. Allow me to explain: Physicians are smart and capable problem-solvers with excellent interpersonal skills and the ability to adroitly navigate a complex, evolving health care system. However, for even the very best physicians, use of a psychoactive substance or the existence of a symptomatic health condition that interferes with a doctor’s proficiency has the potential to impair performance. Simply, impaired physician performance can jeopardize patient safety.

For this reason, on-duty physicians are expected to be free of the effects of mind-altering substances such as alcohol and marijuana. Furthermore, doctors who have been diagnosed with an addictive disorder are expected to remain clean and sober as long as they continue to practice medicine.

But what about recreational use of alcohol, a legal psychoactive substance, and marijuana, a psychoactive substance that has been decriminalized, medicalized, and legalized in Colorado and Washington? What should practicing physicians who do not suffer from an addictive disorder bear in mind as they consider personal use of alcohol and marijuana?

As for alcohol, I refer to this course of action as “clean-margin drinking.” Physicians without a history of an alcohol problem who choose to drink should consider the following guidelines:

- Never on duty or on call (if you’re reachable, you’re on duty)
- Aim to stay well below the legal limit (impaired cognitive performance commences at 0.05)
- Women: one to two standard drinks per sitting; Men: one to three drinks per sitting (even less on nights before you are scheduled to work)
- Avoid combination drinking
- Avoid drinking before driving
- Never combine alcohol with sedating medication

What about marijuana? Recreational marijuana use is currently illegal in the Commonwealth of Massachusetts. It continues to be classified in Schedule 1 by the DEA. Schedule I drugs are defined as having no currently accepted medical use and a high potential for abuse. It is never prudent for licensed physicians to violate the laws of the Commonwealth or the guidelines of the DEA.

What about physicians who suffer from debilitating medical conditions that qualify them to obtain and possess marijuana for medical use? This remains uncharted territory. It is possible that some may view physicians with debilitating medical conditions who use marijuana to control pain as unable to practice medicine with optimal skill and safety — either because of the debilitating condition itself, or because of the effects of the substance being used for medication.

However, even when someone may not be under the active effects of marijuana, the mere existence of it in one’s system could pose risks. Unlike alcohol, marijuana use has a biological footprint that lingers in the body for weeks. THC levels sometimes even rise after cessation of use before they decrease and disappear. Because of the pharmacology of THC, and because various regulatory bodies have yet to weigh in on the potentially thorny matter of medical marijuana use in practicing physicians, this poses some particular risks for any use of marijuana by an actively practicing physician. It may be difficult to demonstrate the difference between impairment as a result of the effects of marijuana in the system, and the mere presence of marijuana in the system absent any impairment.

As access and attitude toward alcohol and — in particular — marijuana change in our society, careful consideration must be given to the use of them by those in high-risk professions, including that of medicine.

Physician Health Services, Inc.

A Tribute to Michael Palmer, MD
We Celebrate His Life

October 19, 2014
2:00–4:00 PM • MMS Headquarters, Waltham

Event Program

• Welcome address by Steven Adelman, MD, director, and Edward Khantzian, MD, president, Physician Health Services
• Tribute to Michael Palmer, MD, by Daniel Palmer
• Presentation by Samuel Shem (Stephen Bergman, MD, DPhil) and Janet Surrey, PhD
• Presentation by Mark Vonnegut, MD
• Reading by Luke Palmer

Please visit www.massmed.org/palmertribute to RSVP to attend, donate to PHS, or share a tribute to Michael Palmer in our special tribute book.

NEJM Editor-in-Chief
Arnold S. Relman, M.D., 1923–2014

Arnold (“Bud”) Relman, who served as editor-in-chief of the New England Journal of Medicine from 1977 through 1991, died on June 17 from complications of advanced malignant melanoma. He was 91.

Dr. Relman was a renowned clinician, teacher, and investigator in nephrology. He was professor of medicine and director of the Boston University Medical Services at Boston City Hospital and later became chair of the Department of Medicine at the University of Pennsylvania School of Medicine.

He wrote passionately about many aspects of health care, voicing opposition to the intrusion of business interests into the practice of medicine. Just months before his death, Dr. Relman wrote a compelling article for the New York Review of Books, “On Breaking One’s Neck,” in which he described his experience as a patient after a near-fatal fall, including the cost of his care.

In a recent tribute in NEJM, Dr. Relman’s colleagues wrote the following: “In the increasingly complex world of health care, Bud Relman was a prophetic figure, larger than life. He acted as our conscience. In his writing and speaking, he always reminded us that the medical profession is far more than a business and that as physicians, we have the responsibility to do what is right for patients and for the community as a whole.”
MMS Interim Meeting 2014 is December 5–6

The 2014 Interim Meeting of the MMS House of Delegates will be held Friday–Saturday, Dec. 5–6 at MMS headquarters and the Newton Marriott Hotel.

Online registration for the meeting opens in late September. To make reservations at the Newton Marriott Hotel, please visit www.massmed.org/IM14reservations or call the hotel directly at (617) 909-1000 no later than Nov. 7.

Members may submit resolutions at www.massmed.org/resolutions or via email to resolutions@mms.org through Tuesday, Oct. 21.

For more information on submitting a resolution, please contact Annemarie Tucker at (800) 322-2303, ext. 7332.

Residents/Fellows and Medical Students: Research Poster Abstracts Due October 14

The Ninth Annual Research Poster Symposium, sponsored by the MMS Resident and Fellow and Medical Student Sections, will take place the afternoon of Friday, Dec. 5, 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 Tuesday, Oct. 14.

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

A participant in the Eighth Annual Research Poster Symposium discusses her work at the 2013 MMS Interim Meeting.

ACROSS THE COMMONWEALTH

District News and Events

NORTHEAST REGION

Charles River — Fall Family Outing. Sat., Sept. 6, 12:30 p.m. Location: Maggiano’s, Boston. Lunch followed by Boston Duck Tour.

Middlesex — Jazz Brunch with Balloon Artist. Sun., Sept. 28, 11:00 a.m. to 1:00 p.m. Location: MMS headquarters, Waltham.

Norfolk District — Executive Committee Meeting. Wed., Sept. 30, 6:00 p.m. Location: MMS headquarters, Waltham.

Suffolk — Reception for Students, Young Physicians, and Residents. Thurs., Sept. 18, 7:00 to 9:00 p.m. Location: Clery’s, 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.

SOUTHEAST REGION

Norfolk South — Executive Committee Meeting. Tues., Sept. 9, 6:30 p.m. Location: Abbey Restaurant, Milton.

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

Berkshire — Fall District Meeting. Tues., Oct. 7, 6:00 p.m. Location: Crowne Plaza, Pittsfield. Speaker: Jennifer Michaels, M.D., and John Rogers, Esq. Topic: Medical Marijuana: What Physicians Need to Know. (This activity has been approved for 1.25 AMA PRA Category 1 Credits™.)

Worcester — 23rd Annual Women in Medicine Breakfast. Fri., Sept. 12, 7:30 a.m. Location: Beechwood Hotel. Topic: Covering the Middle East. Speaker: N. Lynn Eckhart, M.D., D.P.H., M.P.H., director for academic programs, Partners HealthCare International; former interim dean, Lebanese American University School of Medicine.

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.

Statewide News and Events

Arts, History, Humanism, and Culture Member Interest Network — Executive Committee Meeting. Tues., Sept. 16, 6:00 p.m. Location: MMS headquarters, Waltham. Creative Writing Workshop. Sat., Sept. 20, Time: 9:00 a.m. to noon. Music and Medicine Event. Wed., Oct. 15, 6:00 to 8:00 p.m. Location: MMS headquarters, Waltham.

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

SAVE THE DATE: UPCOMING SPECIAL EVENTS

Women’s Leadership Forum: Advancing Your Career for Women Physicians

WEDNESDAY, SEPTEMBER 17, 2014, 5:30 TO 8:00 P.M., AT MMS HEADQUARTERS

Sponsored by the Massachusetts Medical Society and its Committee on Women in Medicine

Through lectures and interactive discussion, this activity will provide an opportunity to discuss the unique opportunities and challenges for women physician leaders. Participants will hear from experts on a variety of leadership topics and learn the different career pathways in developing a leadership role.

This program will also feature a networking dinner and presentation of the 2014 Woman Physician Leadership Award to Dr. Carole E. Allen.

For more information, visit www.massmed.org/WLF2014.

Networking Event for LGBT Health Care Providers

THURSDAY, OCTOBER 23, 2014, 7:00 TO 9:00 P.M., AT CLUB CAFÉ, 209 COLUMBUS AVENUE, BOSTON

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

A prix fixe menu will be available for $15 per person (includes tax and tip, but not drinks).

RSVP to Erin Tally at etally@mms.org or (781) 434-7413.

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.

Marie Ehrlich, M.D., 92; Natick, MA; University of Bologna, 1952; died February 29, 2014.

Richard A. Gross, M.D., 66; Plymouth, MA; Case Western Reserve University School of Medicine, 1974; died May 22, 2014.

Robert C. Moellering, Jr., M.D., 77; Boston, MA; Harvard Medical School, 1962; died February 24, 2014.

Murray K. Rosenthal, M.D., 81; Peabody, MA; University of Vermont College of Medicine, 1959; died December 31, 2013.

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  > André Guay, M.D., Receives Men’s Health Award
5 > Closing or Leaving Your Medical Practice
  > Hopes for Revived SGR Reform
6 > Alcohol Use and Physicians
  > NEJM Editor-in-Chief Arnold "Bud" Relman, M.D., 1923–2014
7 > Women’s Leadership, LGBT Events
  > MMS Interim Meeting Scheduled for Dec. 5–6

MMS AND JOINTLY PROVIDED CME ACTIVITIES

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

2014 Women’s Leadership Forum: Advancing Your Career for Women Physicians
Wed., September 17, 2014, 5:30 to 8:00 p.m.

New Trends in Women’s Health: What Every Provider Needs to Know
Fri., November 14, 2014, 8:00 a.m. to 5:00 p.m.

ONLINE CME ACTIVITIES
Go to www.massmed.org/cme

Risk Management CME

End-of-Life Care
• 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 Topics
• 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

Additional CME
• Physician Employment Options in the Health Care 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 Antiplatelet Drugs: A Review of Recent Clinical Trials
• Acid Suppression Therapy: Neutralizing the Hype
• Preventing Overuse of Antipsychotic Drugs in Nursing Home Care

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

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