

VITAL SIGNS



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VOLUME 15, ISSUE 6, SUMMER 2010

MMS Working to Maintain Physician Practice Environment

BY BILL RYDER, ESQ.

Massachusetts is already experiencing many of the issues the nation as a whole is expected to address with the move toward universal coverage. Consequently, the MMS has been hard at work this spring and early summer in the state Legislature.

Expansion of Medicaid eligibility and mandated employer insurance coverage were two key elements of the Massachusetts health reform law (Chapter 58) enacted in 2006. Together these mandates were designed to increase coverage for Massachusetts residents. Massachusetts focused first on improving health coverage and access, with cost and quality-control measures to be fleshed out by several commissions and councils created as part of Chapter 58 and, in 2008, as part of Chapter 305.

Throughout its support for universal access, the MMS insisted on a strong financial basis for coverage. But since 2006, the state budget situation has deteriorated significantly. Tax revenues are down, and unemployment is up. With more patients enrolled in Medicaid/MassHealth, the MMS was concerned that the governor, the House, or the Senate would continue to mandate Medicaid eligibility for a significant percentage of Massachusetts residents and at the same time cut funding in a way that would lead to reductions in provider payment.

The MMS has also been paying close attention to the consequences of the so-called employer mandate. State mandates to cover employees and to provide significant coverage raised costs of small business insurance at a time when the overall economic climate was bleak. Additional cost

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Continuing Decline in Practice Environment Likely to Affect Delivery of Patient Care

Malpractice Costs and ED Crowding Top Factors

BY TOM WALSH

A lot has changed in the 15 years that Joseph M. Bergen, D.O., has practiced emergency medicine — not all of it for the better.

"The emergency department (ED) has become even more of a hub of care than it was when I started," said Dr. Bergen, who practices at Emerson Hospital in Concord. The increasing centrality of the ED has made it more crowded than ever before.

"It's very unpredictable," Dr. Bergen added. "We don't know who or how many are coming in that door. It can be difficult to have enough staff available." One factor causing crowding is patients waiting to be admitted to inpatient beds lingering in the ED hallway.

Practice Environment Decline Continues

Dr. Bergen's assessment of today's emergency department environment in Massachusetts mirrors a key finding in the most recent MMS Physician Practice Environment Index — an increasing use of emergency departments by patients across the state.

"Emergency department patient utilization rates are not only increasing over time in Massachusetts relative to the U.S.," the MMS report found, but also "in 2009 Massachusetts residents turned to emergency departments at a rate 40 percent greater than in the U.S."

The Index is a statistical compilation of nine factors that influence the practice climate, and continuing declines in the Index are likely to adversely affect patients. Overall, the Index report showed yet another decline in the physician practice environment, this time by 0.8 percent. The report has shown a decline in 16 of 18 years. Since the MMS first started analyzing data in 1992, the state's practice index has fallen by 26.4 percent.

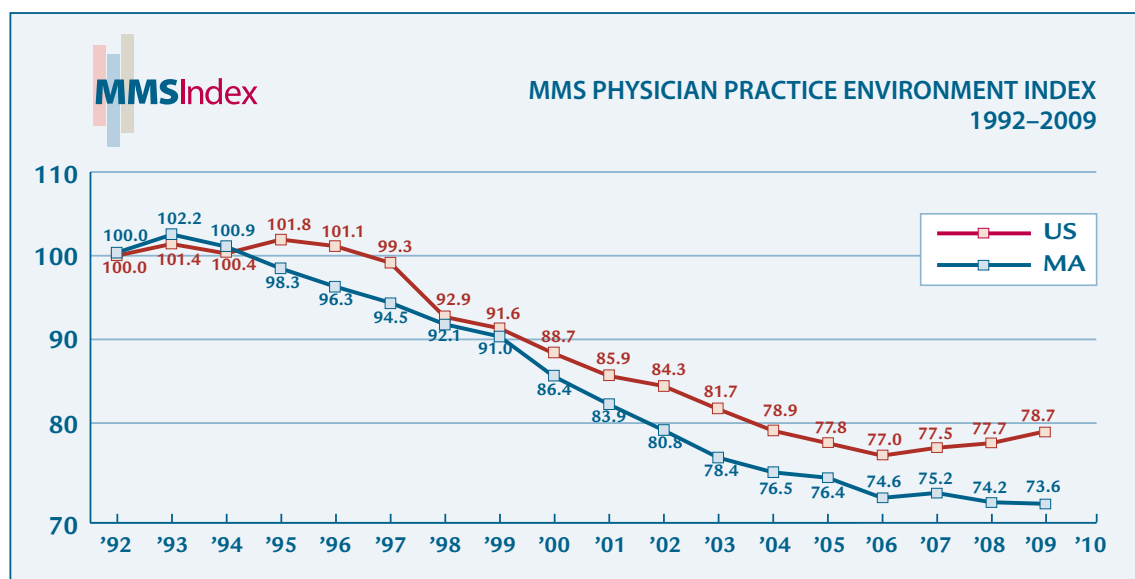
Emergency department overcrowding was one of four key factors cited by this year's Index in the continuing decline of the practice environment. The other three were professional liability rates, percent of physicians more than 55 years old, and the cost of maintaining a physician practice (see table on page 2).

Liability Reform Needed

"The causes of the sustained decline in the practice environment have been with us for some time," said Alice Coombs, M.D., MMS president. "This analysis is significant because it carries implications for patients as well as physicians."

Dr. Coombs added that the Index findings are important in light of the state's health care reform effort. With more patients now insured and seeking

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PRESIDENT'S MESSAGE



Balancing Science and Service

Excerpted from the Inaugural Address on May 15. Watch a video excerpt of Dr. Coombs' remarks at www.massmed.org/coombsinaugural.

We're here tonight because we heard and followed the calling to heal our fellow human beings in their time of need. It's a powerful calling, with great responsibility that we must temper with humility and patience.

The diversity of talents within the MMS gives us an endless opportunity to advocate for our patients and the physicians upon whom they rely.

We're *scientists*. We love data, and there aren't many people who love data more than I do. But we're also *servants*. We do the right thing when we serve our patients, first and foremost. In no other profession is balancing these two imperatives so important.

We struggle when that equation becomes imbalanced. When we're too much the scientist, we lose our connection with the person we're trying to help. When we're too much the servant, we fail to use the rigor and knowledge that we've learned. When there's a just balance... life works.

There is also both science and service to what we do as a medical society. And it's even more complex, because we must balance our service to both physicians and patients.

We have some difficult decisions to make this year, and many conversations to have — with each other, with our patients, and with the community at large. We will never go wrong if we remain humble and patient, and follow the calling that brought us here.

Thank you for the privilege of serving you for the next year.

Alice T. Coombs, M.D.

Practice Environment Index

continued from page 1

care, there is added pressure on physicians, especially those in primary care specialties.

"The continued viability of physician practices should be a cause for concern about our state's health care delivery," Dr. Coombs said. "A strong practice environment is essential to maintain a strong physician workforce, and both together mean better care for our patients."

Dr. Coombs described the high cost of professional liability rates — which exceeded 10 percent of total business costs for roughly half of Massachusetts physicians — as "the driving force behind the decline of the practice environment for years." And, she added, "If there's one step to take to begin to reverse the decline, it would be enacting liability reform." Liability reform, she said, would cut overall health system costs by reducing the practice of defensive medicine. A 2008 MMS study conservatively estimated the annual cost of defensive medicine in Massachusetts to be \$1.4 billion.

ED "More Convenient" than Primary Care

On the ED issue, the MMS Index analysis found that 54 percent of the 18- to 64-year-old population sought access to local emergency departments simply because "...it was more convenient to do so." The report called this finding "most disturbing," especially in light of ongoing efforts to rebalance the health care system between emergency departments and primary care physicians.

Dr. Coombs cited an interesting piece of ED data: people who come directly to the ED rather than first consulting a primary care physician often arrive at the ED between 9 a.m. and 5 p.m., not during nighttime and off-shift hours, as one might expect. One possible reason for that: Some of these patients cannot get a primary care appointment in a reasonable amount of time. "It sometimes takes three to six months," Dr. Coombs said. "That delay may be why so many people come to the ED."

Dr. Bergen agreed. "One factor driving ED crowding is not having enough primary care," he said. "Our state has historically not been good at retaining primary care physicians. Patients who might have been nonurgent previously are unable to see anyone. So when we finally see them, they often are in emergency situations."

The Index noted an overall 3.5 percent increase in patient visits to Massachusetts EDs between 2008 and 2009. But Dr. Bergen observed that pressure on

Factors Affecting Practice Environment: Massachusetts vs. U.S.

Practice Environment Factor	2008–09 % Change in MA	2008–09 % Change Nationwide
Malpractice Costs	+4	0
Patient Visits to ED	+3.5	+2.8
Physicians Older than 55	+3.2	+2.6
Practice Costs*	+3.0	–1.3

*Includes wages, office rental, and medical supplies

hospital emergency departments is uneven across the state. "It has not gone up as much in areas of the state where there is higher commercial insurance penetration," he said. "But it has increased considerably in places where state-supported coverage has had more of an impact."

ED Traffic Jams

Emergency department patients, Dr. Bergen observed, can become frustrated and even angry. "Patients get frustrated when it takes so long to go to an inpatient bed once they know they are to be admitted," he said. "The ED beds are not very comfortable, and feeding is not as efficient. We have to limit visitors to the patient because of space considerations. It is trying on patients who are ill to be waiting in this less-than-ideal environment."

Dr. Bergen added that when he began his emergency medicine practice, more ED patients arrived as referrals from a primary care physician. Today, he said, more patients who think they need to be in a hospital come straight to the ED to initiate care. That means EDs today have to be much more involved in time-consuming patient evaluations.

Dr. Coombs said that as patients gain access to health coverage, they need to be provided with information about how best to use the system. "You almost need someone in the health care delivery system coaching patients to get them to the health care environment they need to be in," she said.

She concluded that the MMS has and will continue to be a strong advocate for reforming the professional liability system and for increasing the primary care workforce in Massachusetts. "This is all part of a much larger picture," she said. "Whatever we do with any reform, we have got to improve patient health care." **VS**

To read the complete Index report, go to www.massmed.org/mmsindex.

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New Guidance on Security Requirements Now Available on MMS Website

Bad news first — Medical practices now have (or will soon have) two new security regulations to comply with. The good news is that the MMS recently posted online guidance to help members understand and meet these requirements.

The first regulation — the Written Information Security Program (WISP) — requires the development, implementation, maintenance, and monitoring of a comprehensive security program applicable to all records containing the personal information of Massachusetts residents.

For WISP purposes, “personal information” is defined as a Massachusetts resident’s first name or first initial and last name in combination with *any* of the following:

- A Social Security number
- A driver’s license number or state-issued ID card number
- A financial account number or credit/debit card number

MMS members can find more details and guidance on implementing a WISP at www.massmed.org/wispguidance.

Beginning on January 1, 2011, the Red Flag Rules will define what a “creditor” must do to implement an identity theft prevention program. These rules

apply to any entity that allows for payment of services after the services are provided or via installment payments over time. If a physician does not provide all services on a pay-as-you-go basis, the physician probably qualifies as a creditor.

Developing an identity theft prevention program involves four steps:

- Identify relevant red flags, which are patterns, practices, or activities that indicate the possible existence or high risk of identity theft.
- Develop methods for detecting the identified red flags.
- Implement a plan to respond appropriately to any detected red flags.
- Reevaluate your program periodically to address new risks as the threats from identity theft evolve.

The Red Flag Rules also set out requirements on how to incorporate an identity theft prevention program into the daily operations of your business.

For more details and guidance on implement-

ing an identity theft prevention program in your office, go to www.massmed.org/redflagguidance. **VS**

— Adam Shlager



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Health Plan Audits: Reducing Your Risk

Both government and commercial health plans have stepped up auditing activity in attempts to reduce inappropriate payments and recoup money. Medical groups should protect themselves by ensuring that their coding and documentation practices are in compliance with guidelines.

The following are some proactive steps you can take:

- Consider an annual audit (10 randomly selected charts per physician) by a certified professional coder. Such an audit will provide valuable insight into your practice’s risk in the event of an outside audit and demonstrate the effectiveness of current coding and reimbursement practices. Incorporate the feedback into your medical documentation.
- Make sure your billing department is properly educated on current billing rules. Set up monthly update meetings with billing staff to brief them on changes in health plan payment policies and billing/coding policies.
- Make sure documentation is complete for each visit. If you use paper records, make sure each visit’s documentation is signed off with a legible signature. If you use electronic records, make sure each visit’s documentation is electronically signed off and the record closed in a timely fashion. Make sure everyone understands how to properly close a record in the system.

One of the most active auditing entities in the region is Diversified Collection Services (DCS), the Recovery Audit Contractor (RAC) working for the Centers for Medicare and Medicaid Services.

The DCS website (www.dcsrac.com/issues.html) has valuable information for physicians, as does the RAC Report (http://ezines.hcpro.com/publication/archives/03312010_6895.html). The latter site includes tips and training about the Medicare RAC program. **VS**

— Adam Shlager

MMS Regional Offices to Host Claims Consultations

During August and September, MMS regional offices will once again cohost problem-solving work sessions to help MMS physicians adjudicate troublesome health plan claims.

Representatives from the health plans listed in the accompanying table will be available to review claims with physicians and their office staff and to answer claims-processing questions.

Thirty-minute appointments with each plan can be scheduled for the dates and locations listed. Physician offices are eligible for one appointment per plan, but more than one person from an office is welcome to attend. **VS**

— Tracy Ledin

For more information, contact one of the three regional offices listed at the end of “Across the Commonwealth” on page 7.

Health Plan	Holyoke August 3	Waltham August 19	Lakeville September 16	Worcester September 17
BCBSMA	X	X	X	X
Fallon Community	X	X	X	X
Harvard Pilgrim	X	X	X	X
Health New England	X			
MassHealth	X	X	X	X
Medicare/NHIC	X	X	X	X
Neighborhood Health Plan	X	X	X	X
Tufts Health Plan	X	X	X	X

MMS Funds Patterson Prize at BU School of Public Health



Photo by Gus Freedman

Whitney Cowell, second from left, a graduate of Boston University School of Public Health (BUSPH) with a concentration in environmental health, was presented with the first annual Dr. William B. Patterson Memorial Prize for Excellence in Environmental and Occupational Health in May. The honor acknowledges exemplary academic performance and dedication to research in environmental and occupational health. The award was established by the MMS Foundation with contributions from the friends and family of William B. Patterson, M.D., a faculty member in the Environmental Health Department at BUSPH who passed away in March of 2008. The annual prize commemorates Dr. Patterson's commitment to public health, medicine, and education. Also pictured are (left to right) Roberta White, Ph.D., environmental health chair at BUSPH, and four members of Dr. Patterson's family — Joshua, Rachel, Lisa, and Stuart.

Video Games Can Spark Photosensitive Seizures

On any given day, 60 percent of young people in America play video games, and those who do spend an average of nearly two hours at it. Those findings come from a recent Kaiser Family Foundation study on media use among kids 8 to 18 years of age. But with that frequency and intensity of video game use comes the risk of visually induced seizures.

While these so-called “photosensitive seizures” are not common, they are the most common form of “reflex epilepsy” and are almost certainly more prevalent than physicians know. In one study, seizures triggered by electronic media represented approximately 10 percent of all new cases of epilepsy in young people between the ages of 7 and 19.

Following a 1997 incident in Japan, when about 700 children went to hospitals after experiencing seizures during a *Pokémon* cartoon broadcast, it became clear that photosensitivity was probably not rare. Three-quarters of those

children had no known seizure history.

Subsequently, video game manufacturers began providing warnings about the risk of seizures from video games. Video games are more likely than TV to trigger seizures because users typically look at the screen from a short distance and for extended periods without breaks.

When taking a routine history from a young person and family members, physicians can help uncover symptoms or behaviors suggestive of photosensitive seizures. Inquire about the signs of a partial seizure, which include abrupt mood changes, altered vision, incontinence, confusion, involuntary or unusual movements, and lack of responsiveness.

Although many people have trouble turning off video games because they are so “into it,” extreme difficulty may suggest the presence of subtle seizures. And because seizures can impair a player's skills and performance,

Charitable Foundation Awards 2010 Grants

In April, the MMS and Alliance Charitable Foundation awarded grants totaling \$150,000 to support health and medical services delivered by agencies across the state. The 11 recipients included the following:

Boston Coalition for Adult Immunization — \$20,000 to support flu and pneumonia vaccination for underserved, at-risk adults and for training 250 medical and nursing students

Boston Health Care for the Homeless — \$10,000 to support shelter-based medical services at the Pine Street Inn Clinic

Community Health Center of Cape Cod — \$15,000 to support a patient referral program that connects the uninsured with the services of a physician specialist or surgeon

Father Bill's and MainSpring — \$10,000 to support a nurse practitioner at MainSpring Clinic in Brockton, where more than 50 homeless patients per week are given basic medical care and physician referrals

Katie Brown Educational Program — \$5,000 to support the expansion of relationship violence prevention programming to students in the Fall River area

MetroWest Free Medical Program — \$15,000 to support volunteer physicians providing free health care to the medically underserved and to expand chronic disease prevention and management efforts

Open Door Free Medical Program — \$10,000 to support the expansion of comprehensive women's health services to the un- and underinsured in the Marlborough/Hudson communities

Peer Health Exchange — \$20,000 to support the training of 400 volunteers from six college sites to deliver a comprehensive health-education curriculum to 3,300 ninth-grade students in Boston public schools

Project Health — \$20,000 to support implementation of a universal screening system at Boston Medical Center's pediatric clinic

Sharewood Project — \$10,000 to support health care services provided by volunteer medical students to medically vulnerable residents at weekly clinics in Malden

Volunteers in Medicine Berkshires — \$15,000 to support a part-time clinic manager to coordinate the scheduling of providers and medical interpreters **VS**

gamers experiencing seizures may develop an especially strong desire to continue playing until they regain their facility.

Here's how patients can reduce vulnerability to seizures while playing video games:

- Take frequent breaks;
- Avoid playing when fatigued or sleep-deprived;
- Move back from the screen so it fills a smaller portion of the visual field;
- Dim the screen, use a monitor glare filter, or wear dark lenses;
- Cover one eye.

If seizures occur only in response to a specific visual trigger or under certain conditions, the patient can verify the cause/effect by temporarily halting exposure to the presumed triggering stimulus to see if symptoms remit. Some patients with extreme visual sensitivity may need to avoid exposure entirely.

Only about 25 percent of those with photosensitive seizures outgrow the condition, usually in their early twenties. However, our current understanding is that such seizures do not progress into the types of epilepsy involving spontaneous seizures.

— Michael Rich, M.D., M.P.H.
Children's Hospital Boston

FEDERAL UPDATE

The SGR Saga: Will It Ever End?

“Here we go again” does not even begin to describe it.

As this issue of *Vital Signs* went to press, the 21-percent Medicare payment cut was in effect, as Congress failed to stop the cut before June 1. Prior to that, what was considered by some to be the “best” proposal on the table would have stopped the cut for five years and made modest increases in physician payments, while leading again to significant cuts at the end of that period. The AMA opposed that proposal, which seemed doomed even before it received any serious legislative consideration.

None of the proposals considered in late May would have permanently changed the flawed SGR-based formula, as congressional leaders clearly believed there was insufficient political will in Washington to pass a higher-cost, long-term solution without the money to pay for it.

This entire nightmare is playing out amid the most toxic political environment of our lifetime, a comatose economy, and lots of

promises from people in power who have yet to... well, put the money where their mouth is.

We do know that all the members of the Massachusetts House Delegation and Sen. John Kerry have voted with us each time on this issue. We remain grateful for their support. MMS advocacy is now focused on Sen. Scott Brown, who is critically important to our success on this issue.

This entire nightmare is playing out amid the most toxic political environment of our lifetime.

In late May, the MMS formed a coalition of Massachusetts stakeholders that met with Sen. Brown and his staff in Washington. That coalition included the AARP Massachusetts, the Massachusetts Hospital Association, the Conference of Boston Teaching Hospitals, the Military Officers Association of America, and Philips Healthcare Division.

The MMS-led coalition emphasized that the Medicare crisis is as much about jobs (one in five Massachusetts workers is employed in health care) and the state’s economy (about 15 percent of which is based on the health care industry) as it is about access to care for the more than 1 million Medicare patients in the state and the 71,000-plus members of military families who get care through Tricare.

Notwithstanding any short-term patch that may or may not have been implemented after this issue of *Vital Signs* went to press, organized medicine is forming coalitions to strategize ways to get a long-term Medicare fix passed. The nationwide AMA ad campaign launched in June is one approach.

As we have been telling Congress for a decade, unless the band-aid approach is scrapped, the fiscal hole being dug more deeply with every short-term patch will only get deeper. **VS**

—Alex. Calcagno

MMS Advocacy on Beacon Hill

continued from page 1

pressures on small business premiums have come from the pooling of business clients and nongroup clients and from the aging of the Massachusetts workforce.

So Far, So Good

The good news in the state budget process is that the governor and the Legislature have honored their commitments to access by providing for full funding for MassHealth for the coming fiscal year.

Concerns arose recently about not getting anticipated federal approval of increased federal matching funds. This wild card was pending as this issue of *Vital Signs* went to press. While MassHealth fee-for-service rates are not expected to increase for physicians, neither are they expected to decline or be withheld.

During the budget process, the MMS worked with coalitions of providers to ensure defeat of floor amendments offered by managed care supporters to end fee-for-service payments and the Primary Care Clinician program. Also defeated was a floor amendment mandating that facilities without contracts with Medicaid managed care organizations (MCOs) accept Medicaid rates when seeing patients enrolled in an MCO.

Another amendment introduced by the managed care trade organization would have mandated that physicians participate in small group insurance plans and accept a fee schedule based on a percentage of Medicare reimbursements as full payment — or lose their medical license. Rallied by the MMS, Massachusetts physicians so vehemently opposed this proposal that the sponsor withdrew the amendment before it was even debated.

An additional area of concern for the MMS has always been protecting the physician-patient relationship. In the spring, the MMS successfully defeated a proposed amendment that would have required all physicians, under the threat of criminal fines and sanctions, to report suspected cases of welfare fraud. The MMS argued that physicians have no direct knowledge of most patients’ financial status and that the physician’s role is to assess and address issues with clinical impact upon patients.

Ongoing Budget Vigilance

MMS efforts to advance professional liability reform in an outside section of the fiscal year 2011 state budget were ruled to be outside the scope of a budget bill and hence were not debated on the floor. Sen. Robert O’Leary offered language that would have implemented the so-called “I’m

Sorry” clause, making any statements of apology or sympathy made by health care providers inadmissible in a subsequent legal action. Sen. O’Leary’s provision also would have allowed for “early disclosure” and required a six-month cooling-off period before legal action could be initiated against a health care provider.

The MMS has reviewed all budget amendments for their impact on the physician practice environment. We have focused on analyzing cost measures and advocating for sustainable access to care and are pleased that our efforts have so far carried the day.

Problematic Bills Lurking

However, winning in the budget arena does not mean the end of flawed legislative cost-containment initiatives. Stand-alone bills will continue to be debated until the Legislature’s formal session ends on July 31. The MMS will also exercise ongoing vigilance to prevent damaging bills from going through on a voice vote during informal legislative sessions, which begin on August 1.

Among those problematic bills still lurking is one that would allow the state to set rates for health care providers in contracts with private insurers. Years ago, the Commonwealth briefly implemented rate-

setting for hospitals, but that plan was eliminated because it worked on a cost-plus basis that was seen as highly inflationary and unfair. In past years, however, rate-setting did not encompass individual physician rates. Now the Division of Insurance is actively fighting premium increases requested by insurers, and insurers are seeking to have similar rate reviews for all providers.

The MMS is working hard to focus cost-containment efforts in two key areas — administrative simplification and professional liability reform designed to minimize defensive medicine. Conversely, insurers are focusing concerns on providers and are fighting to protect profits by arguing for loss-ratio mandates that they already meet. A key insurer initiative in this area would mandate participation in small-business health plans as a condition of licensure. So far, these bills have had some support in committees but have not advanced to the floor of the House or Senate.

The MMS will remain steadfast in its efforts to support legislation that provides meaningful cost improvements for patients, improves the practice environment, and eliminates threats to practice viability and violations of the physician-patient relationship. **VS**

PHYSICIAN HEALTH MATTERS

Professional Boundary Considerations for Physicians

When it comes to professional boundaries, doctors are probably held to a higher standard than other professionals. This is largely because of the significant “power differential” between physicians and patients. Physicians have the knowledge and capacity to diagnose, support, and treat, while patients rely upon the physician to bring them relief in vulnerable moments.

A patient’s reliance on a physician for bodily well-being creates a unique dynamic. The doctor’s license to ask intimate questions, to learn about a patient’s habits, and even to touch the patient makes it incumbent upon the physician to protect this trusted relationship in all interactions with the patient.

Even when a patient has similar education, employment status, or social interests as the doctor, the power differential remains.

Professional boundaries between physicians and patients extend beyond predatory behavior or sexual interactions. Boundaries must be considered in any interaction where a physician might be perceived to have personal interests that conflict with those of the patient or where a physician’s actions might fall outside the realm of behavior that would instill public confidence in the physician.

For example, a physician may determine in the course of conversation that a patient is seeking investment opportunities. The same physician may need a loan. If the physician borrows money from the patient, even with the proviso that he or she will pay it back with interest, he or she is engaging in a transaction that has the appearance of and/or the capacity for taking advantage of the power disparity. This type

of transaction would constitute a professional boundary violation that could become the basis for professional discipline.

Likewise, a violation of professional boundaries can occur if a physician meets with a patient in an unprofessional setting. Even if the doctor is doing this as a convenience to the patient, there is potential for such an interaction to be viewed as unprofessional and contrary to the expected deference that a physician must give to the doctor-patient relationship. Accordingly, meeting a patient in a coffee shop to provide medical advice, care, or even a prescription would create professional boundary concerns.

The Massachusetts Board of Registration in Medicine has repeatedly disciplined physicians for “conduct that undermines public confidence in the integrity of the medical profession.” So even if an interaction is intended to benefit a patient, if the action falls outside of the scope of the formal doctor-patient relationship, it could undermine the relationship generally and cast aspersions on the profession as a whole. Therefore, physicians must always be mindful not only of how they act with their patients but also of how their actions could be viewed by others.

Along with the privilege of practicing medicine comes the responsibility of understanding the influence doctors have over patients. Maintaining clear, professional boundaries respects the unique status afforded the medical profession within the community at large. **VS**

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

SAVE THE DATE — SEPTEMBER 21

Women in Medicine Leadership Symposium

MMS Headquarters, Waltham

Dinner: 5:45–6:30 p.m. Program: 6:30–8:00 p.m.

For more information, contact Erin Tally at etally@mms.org or (781) 434-7413.

PHS Director Recognized



Luis Sanchez, M.D., director of Physician Health Services (PHS), received a 2010 Endowment Award for Leadership in the Advance of Mental Health from Kathleen Ulman of the Massachusetts General Hospital’s Center for Psychoanalytic Studies. Dr. Sanchez was recognized for his major contributions to the mental health of Massachusetts citizens through PHS’s work with impaired physicians.

The Legal Advisory Plan: An Exclusive Member Benefit

In the past, many malpractice policies covered legal expenses related to Board of Registration in Medicine (BRM)



actions. Now, however, many policies only cover those complaint-related costs when bodily injury is involved.

So, you may have a hole in your professional liability umbrella of which you are unaware.

For years, the Legal Advisory Plan (LAP) has offered prepaid coverage that helps physicians with legal advice for board-specific matters. For only \$70 a year, the LAP offers members a free 30-minute consultation, legal representation, and advice. LAP members also receive *The Legal Advisor*, a quarterly newsletter with information about changing laws, malpractice issues, and BRM decisions. Select newsletter content is also now available as online CME at an exclusive member discount.

Join the Legal Advisory Plan today and help plug any legal insurance gaps. **VS**

—Carolyn Maher

For more information about the LAP or to enroll, call (800) 322-2303, ext. 7312, or e-mail lap@massmed.org.

Med Students Host Health Fair

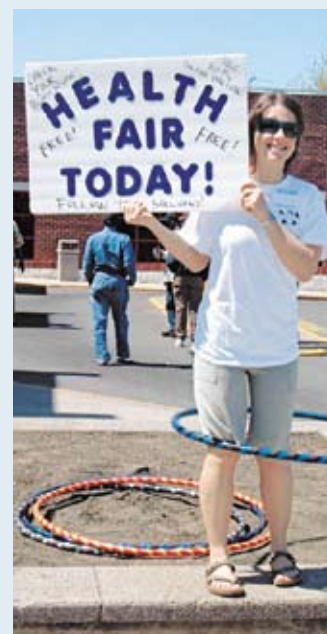


Photo by Colleen Hennessey

On April 24, more than 30 members of the MMS Medical Student Section conducted a free health fair for the residents of Roxbury. More than 110 members of the community participated in the four-hour fair, which offered adults 18 and older free health screenings for blood pressure, blood sugar, and body mass index.

In a related event, medical school students from Massachusetts, Rhode Island, Connecticut, and New York organized a medical student bicycle relay from Boston to Rochester, New York.

MMS Membership Reaches All-Time High of 22,950

Membership in the Massachusetts Medical Society has reached an all-time high of 22,950. As the Society becomes a stronger and more compelling force within the health care environment, our influence on local and national advocacy issues strengthens.

This past year, new members were attracted to the Society through our group discounts for physician groups, lifetime and part-time membership options, and special offers via CME live and online programs and health policy surveys. Also playing a role

in our record-setting membership numbers were the peer recruitment program, member-only online practice management tools, direct-mail programs, multiyear discounts for individual physicians, and our dues-exempt resident enrollment program.

Thanks to everyone for spreading the word about the Society's mission, benefits, and services and for helping us to prove that "every physician matters and each patient counts." **VS**

— George Dudley

Valuable Vouchers

To thank MMS members who volunteer their time in committee, section, and task force pursuits, as well as those who serve on the Board of Trustees, House of Delegates, or as district medical society presidents, the MMS awards vouchers. These vouchers can be used in lieu of program fees for MMS-sponsored events, including live and online CME programs and annual and interim meetings.

Members may be eligible to receive between \$100 and \$400 worth of vouchers, which are good for two years.

All voucher activity, including balances and expiration dates, will be tracked electronically in the member database system. To view your voucher information, including any carryovers from the previous year, log onto www.massmed.org, and click on "My Vouchers" in the "My Membership Information" box.

If you have any questions about the voucher process or voucher redemption, contact Carolyn Maher at (800) 322-2303, ext. 7311, or cmaher@mms.org. **VS**

— Carolyn Maher

IN MEMORIAM

The following deaths of MMS members were reported to the Society in April, May, and June 2010. We also note member deaths on the MMS website at www.massmed.org/memoriam.

Jane V. Anderson, M.D., 78; Newton, MA; Boston University School of Medicine, 1960; died February 26, 2010.

Richard L. Berkman, M.D., 73; Haydenville, MA; New York University School of Medicine, 1960; died August 13, 2009.

Earle O. Brown Jr., M.D., age unknown; Williamstown, MA; Albany Medical College, 1947; date of death unknown.

Clement C. Curd, M.D., age unknown; Lenox, MA; Columbia University College of Physicians and Surgeons, 1946; date of death unknown.

Marie-France Demierre, M.D., 43; Boston, MA; McGill University Faculty of Medicine, 1991; died April 13, 2010.

Ralph H. Goldstein, M.D., 80; Medford, MA; Tufts University School of Medicine, 1955; died April 11, 2010.

Robert M. Goldwyn, M.D., 79; Brookline, MA; Harvard Medical School, 1956; died March 23, 2010.

Howard D. Kirshenbaum, M.D., 61; Sudbury, MA; Harvard Medical School, 1974; died May 26, 2010.

Alexander MacDonald Jr., M.D., 94; Bristol, VT; Cornell University Medical College, 1941; died May 2, 2010.

Arnold Margolin, M.D., 73; Hingham, MA; Columbia University College of Physicians and Surgeons, 1961; died August 26, 2009.

John J. McCue, M.D., 84; North Falmouth, MA; St. Louis University School of Medicine, 1954; died April 21, 2010.

Robert P. Newman, M.D., 65; Longmeadow, MA; New York Medical College, 1970; died April 10, 2010.

Robert M. Phillips, M.D., 93; Winchester, KS; Middlesex University School of Medicine, 1943; died May 25, 2010.

David E. Rosengard, M.D., 91; Lexington, MA; Tufts University School of Medicine, 1945; died September 13, 2009.

Robert L. Seaver, M.D., 70; Holyoke, MA; University of New York College of Medicine, 1964; died April 23, 2010.

William R. Shelton, M.D., age unknown; Watertown, MA; Ohio State University College of Medicine, 1945; date of death unknown.

S. Norman Sherry, M.D., 83; Cambridge, MA; University of Maryland School of Medicine, 1951; died April 5, 2010.

Francis A. Slowick Jr., M.D., age unknown; Pittsfield, MA; Tufts University School of Medicine, 1961; date of death unknown.

ACROSS THE COMMONWEALTH

District News and Events

Barnstable – Legislative Committee Meeting. Fri., June 25, 7:30 a.m. Location: Faxon Conference Room, Falmouth Hospital, Falmouth. For more information, contact the Southeast Regional Office.

Berkshire – Executive Committee Meeting. Tues., July 13, 6:00 p.m. Location: Dakota Restaurant, Pittsfield. For more information, contact the West Central Regional Office.

Essex South – Executive Committee Meeting. Wed., July 14, 6 p.m. Location: Tom Shea's Restaurant, Essex. For more information, contact the Northeast Regional Office.

Franklin – Executive Committee Meeting. Thurs., Aug. 12, 7 a.m. Location: Conference Room A, Baystate Franklin Medical Center, Greenfield. For more information, contact the West Central Regional Office.

Middlesex Central – 5th Tuesday Meeting. Tues., June 29, 11:45 a.m. Location: Emerson Hospital, Concord. Guest Speaker: Alice Coombs, M.D., MMS President. For more information, contact Carol Marshall at (978) 287-3017.

Worcester North – Executive Committee Meeting. Thurs., July 29, 6:00 p.m. Location: Lidio's Restaurant, Leominster. For more information, contact the West Central Regional Office.

Statewide News and Events

Arts, History, Humanism, and Culture Member Interest Network – Tower Hill. Sat., Oct. 16, 6:00 to 9:00 p.m. Members are invited to participate and/or attend the Music and Medicine program being held at Tower Hill Botanic Garden in Boylston. 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.

2010 MMS Presidential Ceremony



Photo by Doug Bradshaw

Incoming MMS President Alice T. Coombs, M.D., (left) receives the presidential medallion from Immediate Past President Mario E. Motta, M.D.

For more details about the Annual Meeting in May, go to www.massmed.org/annual2010.

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MASSACHUSETTS
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VITALSIGNS

VOLUME 15, ISSUE 6, SUMMER 2010

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