

WORCESTER medicine

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Mindfulness and Beyond



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Editorial

Jane Lochrie, M.D.



Jane Lochrie, M.D.

More than 38.2 percent of adult Americans use medical treatments that are outside of mainstream conventional medicine, and they spent \$33.9 billion on these treatments. These therapies are referred to by different names, including complementary, integrative or alternative medicine (CAM). The National Center for Complimentary and Integrative Health, a branch of National Institutes of Health, has been applying vigorous scientific

methods in studying these techniques. Its plan is “to give increased emphasis to translational research as the core of building the evidence base for CAM.” Today, we will explore some of these treatments.

Hari-Kirin Khalsa, MD, reminds us that the electronic world has brought our work life into our time with our family and friends, causing “compassion fatigue.” Through mind-body practices, we can spend a few minutes a day developing a meditative mind, which can bring a calming awareness to everything we do, including patient care – the true meaning of “physician, heal thyself.”

Sara-Grace Reynolds, an intern at St. Vincent Hospital, explains that clinicians in the medical profession are surrounded by suffering. Though we see this every day, often we are powerless to change it. The nature of suffering is determined by how one responds to it. She outlines three mindfulness techniques to “go into our own mind” and help us cope with things that we cannot alter.

The team from the Department of Psychiatry at University of Massachusetts Medical School (UMMS)/UMass Memorial HealthCare (UMMHC) describes how they successfully integrated mindfulness activities into the Department of Psychiatry. The UMMS Center for Mindfulness (CFM) was founded by Dr. Jon

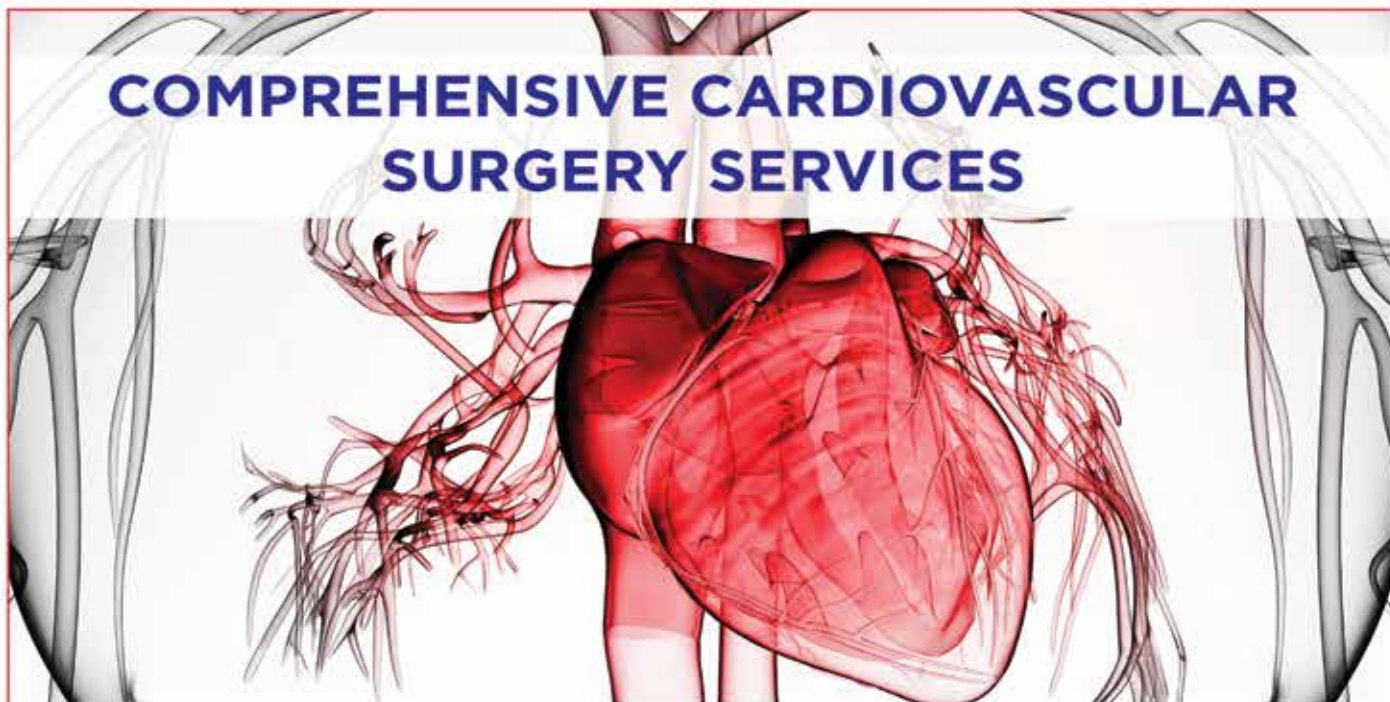
Cabot-Zinn in 1979, and the center is recognized as global leader in Mindfulness Based Stress Reduction (MBSR) for training and certifying MBSR teachers. The Mindfulness in Psychiatry Program was established in 2008 to improve patient care, provide support and an initial introduction to interested members of the department and expand research in this area. Because of its success, this is becoming a campus-wide initiative, with drop-in meditation sessions, CME events and training opportunities.

Lynn Gerrits, MA, gives a heart-wrenching account of caring for her husband with cancer and how her skill set with stress management and holistic medicine prepared her and her family to deal with his illness. Who better to manage the recently opened Simonds-Hurd Complementary Care Center at HealthAlliance Hospital? She describes a plethora of options to manage the trauma of the diagnosis and the side effects of cancer treatments. These therapies have been shown to reduce physical symptoms and improve emotional wellness and quality of life.

We are much honored to present the three 2016 MMS Creative Writing Exposition Award-winning prose and poetry entries. Alexander White, MD, writes a very intimate account of his struggle to accept his wife’s diagnosis of Multiple Sclerosis. He likens this to the weather – you learn to cope. In closing, he states, “We can handle it, no matter what comes. Together.” The second essay was written by Laura Prager, MD, a child psychiatrist who believes in giving gifts to her patients. She opines that the gift itself is less important than the therapist’s understanding of its meaning to the child and the child’s ability to accept the feeling it provokes. She relates a very personal story of being a recipient of such a gift and how it affected her. In her poem, “The Biopsy Results Are In,” Dr. Robin Schoenthaler relates her experiences with telling patients their cancer diagnosis in a very special fashion.

As always, we are delighted to have a Legal Consult from Attorney Peter Martin, this time on how HIPPA breaches in medicine are being interpreted in the legal system. As always, please take time to read the President’s Message, Society Snippets and In Memoriam for Dr. Samuel Pickens.

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Frederic Baker, M.D.



Frederic Baker, M.D.

According to the Centers for Disease Control, it's estimated that more than one-third of U.S. adults are obese. Obesity accounted for \$147 billion in U.S. medical costs in 2008. Medical costs for people who are obese are estimated at \$1,429 higher than those of normal weight. Those costs are attributable to obesity-related conditions that include heart disease, stroke, type 2 diabetes and certain types of cancer, some of the leading causes of preventable death.¹ Increases in obesity prevalence alone account for 12 percent of the growth in health spending.² A National Institutes of Health study noted extreme obesity may shorten life expectancy up to 14 years.³ Congressman Jim McGovern refers to "the national security

crisis of obesity," citing how being overweight is now the leading cause for rejection from military service, with excess weight accounting for 27 percent of young adults unable to serve in the military.⁴ Many authors note the problem of obesity in America has no single cause and that strategies to address obesity must take into account the result of multiple variables acting together over time.⁵

Just what can be done to reverse such disturbing trends? It's worth noting the findings from the CDC that when it comes to influencing healthy outcomes, physician contribution as part of clinical care only accounts for 20 percent of health outcomes, while health behaviors and socioeconomic factors account for 30 percent and 40 percent respectively.⁶ From the clinical care component, The United States Preventative Services Task Force recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.⁷ The American Medical Association lobbied to have obesity listed as a disease to allow the conversation with insurers to move forward on coverage of various to-be-named treatments, e.g., multidisciplinary programs, behavioral therapy, office visits specific to obesity, etc.⁸

Columnist George Will shares the observations of Leon Kass, a University of Chicago professor emeritus, that humans are the only animals that do not "instinctively eat the right foods (when available) and act in such a way as to maintain their naturally given state of health and vigor. Other animals do not overeat, under-sleep, knowingly ingest toxic substances, or permit their bodies to fall into disuse through sloth, watching television and riding in automobiles..." Although preventive medicine is real, society's level of health does not depend primarily on medicine, which too often must be resorted to when our behavior has forfeited our health.⁹ So just why do we accept and embrace such dysfunctional eating behaviors, given the negative consequences and imperative to change course? U.S. food policy is often cited as the major source of the problem,

with subsidies favoring unhealthy low-nutrient/high-caloric processed foods over healthy ones.¹⁰ Between 1995 and 2009, the United States Department of Agriculture distributed more than \$246 billion in subsidies to "commodity crops," which include more than a dozen nonperishable crops. However, five commodity crops – corn, wheat, soybeans, cotton and rice – receive the vast majority of subsidies to support production of meat and dairy products. Contrast that to the USDA policy of designating fresh fruits and vegetables as "specialty crops," which do not receive subsidies, and factor in a provision, enacted in 1996, that restricts the ability of both small- and large-commodity farmers from diversifying their crops to include fruits and vegetables as part of their production. Many argue that Congress subsidizes the wrong foods in response to heavy lobbying, which would account for the observation succinctly captured by an article titled "Why a Big Mac Costs Less Than a Salad."^{11, 12} From a public health perspective, altering federal agricultural policies is a key part of addressing the behavioral and socioeconomic components of obesity and poor health among Americans.¹³

The harsh reality is that the price of food influences individual consumption and choices of foods. Foods that pack in the most calories, such as fats, sugar and meat, are often cheaper than fruits and vegetables, and that may explain today's unprecedented high rates of obesity. That also has repercussions on the Food Assistance and School Lunch programs. According to the USDA, the cost of feeding a family of four a healthy diet in 2013 ran from \$146 a week on a "thrifty plan" to \$289 a week on a "liberal plan." The thrifty plan is used as the basis of SNAP, the Supplemental Nutrition Assistance Program, formerly known as food stamps. Eating a healthy diet on that amount of money means buying the lowest-cost fruits and vegetables.¹⁴ The added burden of having to pay for just one medication, which can easily surpass \$500 a month for treating certain conditions like diabetes, can be particularly challenging for those on a fixed income, further limiting nutritious options.

More than 30 million children receive a government-supported lunch at school each day through the National School Lunch Program. USDA-purchased surplus meat and dairy products, as well as processed grains, fruits and vegetables, are supplied to schools for use in school feeding programs. The rationale for these purchases is based solely on agriculture support goals, rather than nutrition recommendations.

It's noted that the lack of access to proper nutrition is one reason why many children are not eating the recommended levels of fruits, vegetables and whole grains. More than 23 million Americans, including 6.5 million children, live in low-income urban and rural neighborhoods that are more than a mile away from a supermarket, in the "food deserts," defined as communities where there is limited access to affordable, quality and nutritious foods.

Let's Move! is a government initiative that evolved with a commitment to helping ensure that all families have access to healthy, affordable food in their communities.^{15,16} The World Food Summit of 1996 notes that food security exists "when all people at all times have access to sufficient, safe, nutritious food to maintain a healthy and active life." According to the U.S. Department of Agriculture, 14 percent of U.S. households in 2015 were considered "food insecure compared to 11.1 percent in 2007, before the Great Recession began, despite improving economy. Children with

food insecurity are noted to have more abdominal pain, illnesses, trouble concentrating and difficulty in schools.”¹⁷

According to a 2013 Union of Concerned Scientists report, The \$11 Trillion Dollar Reward, increasing our consumption of fruits and vegetables could save more than 100,000 lives and \$17 billion in health care costs associated with heart disease each year. The report offers the following recommendations:

- Increase our access to locally grown food to increase the consumption of fruits and vegetables in our diet.
- Change our research priorities to enhance funding for healthy foods that could translate to more abundant, varied and affordable fruits and vegetables for consumers.
- Remove planting restrictions from commodity crop farmers, who are barred under current subsidy programs from planting fruits and vegetables. Lifting those restrictions would help create more competitive market conditions for healthy foods.
- Make crop insurance available. Crop insurance is currently unavailable for many fruit and vegetable farmers, making it harder to grow healthy foods profitably. Removing this obstacle should be a priority.
- Promote the growth of farmers markets, food hubs and other local food outlets – especially in underserved areas where access to healthy food is most limited – through grants and low-interest loans.
- Facilitate the use of nutrition benefits such as SNAP at local food markets.
- Educate consumers about healthy foods and how to prepare them.¹⁸ “It is felt that local food pantries offer a great opportunity to provide diabetes education and diabetes support, because they reach so many vulnerable people, and because they have unique expertise in the distribution of food.”¹⁹

Instilling healthy behaviors and practices, particularly during youth, can be as easy and as affordable as making water freely available, particularly in school settings, and thus avoiding the cumulative damage from high-caloric beverages like sodas.²⁰ It’s noted that improving education on nutrition and “the myriad ways obesity affects health could help motivate people to get more active and eat better before full-blown disease strikes.” One poll highlights the lack of knowledge respondents had in linking obesity to certain diseases, with only 7 percent of respondents appreciating the link to cancer; 15 percent to arthritis and 5 percent to respiratory problems such as sleep apnea and asthma exacerbation.²¹

Consumer demand can also positively influence the food industry and foster increased competition in the fast food market to provide healthier options, particularly in this era of healthier food consciousness, advocacy and greater scrutiny of junk food. As *Fortune* magazine put it, “natural, unprocessed, and sustainable” are “qualities that matter more to today’s consumers than ‘low fat’ and ‘low calorie.’” Witness the popularity of films like *Super Size Me*, *Forks Over Knives*, and *A Seat at the Table*, as well as popular PBS shows and books like *Eat to Live* by Dr. Joel Fuhrman and smartphone apps like My Fitness Pal and Lose It, which have consumers scrutinizing nutrition. According to a Nielsen Global Health and Wellness survey conducted last year, 50 percent of global respondents claimed they’re trying to lose weight, and 75 percent of those people planned to do so by changing their diets and focusing on more natural, fresh foods. That might account for why McDonald’s has been losing ground for a while to companies like Chipotle and Panera, as consumers opted for healthier and fresher menu options than the fast-food chain historically has offered. McDonald’s, in response to falling U.S. sales and global sales, transformed one of its Hong Kong branches into the world’s first McDonald’s Next – an evolved version of the brand that strives to be “modern and progressive” by featuring salad base greens and quinoa.^{22 23}

Sometimes it takes great foresight and creativity to ensure that efforts

to pursue healthier outcomes can engage as many partners as possible. We need to resist the often too easy pathway of demonizing, alienating or disproportionately burdening potential partners who might otherwise share in the desire of securing better health outcomes but, for various reasons, have not had such opportunities or incentives. In particular, we must pursue policies that avoid collateral damage of economic hardship on hard-working farmers, small businesses and other industries whose only “sin” was to perhaps sincerely engage in the only livelihoods they have known, that were accepted and often embraced in our culture, and met consumer demand for generations, long before current research and knowledge made some of their offerings socially and medically unacceptable or unprofitable. A great example is that of Sabra, the hummus company, which saw an opportunity to transform tobacco crops into profitable and healthier chickpea crops, sparing many farmers massive economic hardship and, more importantly, engaging them in producing healthy food crops, capitalizing upon the expertise of their farming skills. Embracing healthier food options, investing in healthier food crops and adopting policies that make healthy food more affordable and more accessible should be great for business and consumers alike. America can do better.²⁴

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Mindfulness Saves Lives

Hari-Kirin Khalsa, M.D.



Hari-Kirin Khalsa, M.D.

Mindfulness saves lives. We are constantly distracted by text messages, emails and information overload. We need tools to redirect ourselves. Otherwise, we are not focused. We become unaware of what is needed most, in the present moment, in any situation.

The demands of electronic life take their toll. Previously, there were boundaries between work and home life. Now, we take our work home via electronic medical records. In

some circumstances, it's great that we can access data and not have to leave home. Other times, work accessing *us* is an unwelcome interruption to family time. We find ourselves working all hours of the night on our "nights off." This is a fast recipe for data confusion and compassion fatigue.

As health care providers, we took an oath to first do no harm. That included no harm to ourselves. Somehow, during our training and practices, we adapted to the demands of patient care. As those demands cranked up, we adapted to a new normal, sacrificing the things we used to enjoy.

Self-care is not self-indulgence. When people depend on us, and we keep ourselves healthy, that is an act of love for all. We feel that we are trustworthy in the care of patients. Can we trust ourselves in the care of ourselves? Or do we put ourselves somewhere after feeding the dog and watering the plants?

Through mind-body practices, we develop self-awareness. We can watch our thoughts and emotions without getting attached to them. Once we attach emotions to a thought, we are likely to act, perhaps in a way we will regret. Mindfulness is one of the eight limbs of yoga. Yogic philosophy informs us that all of the natural world is synchronized, but we as human beings have free choice. We have to make the *decision* to surrender to the flow. What does that mean in

plain English? It means that we spend at least a few moments each day developing a meditative mind. When we are in our meditative mind, we are not producing thoughts and actions. We are listening.

As we develop these practices of awareness, we feel calm – with energy. The ups and downs of the day are no longer as upsetting. Studies have shown that regular meditative practices develop the prefrontal cortex, the executive function of the brain, which controls the limbic system. We're no longer slaves to our emotions and reactivity.

How do we find our meditative mind and the richness of each moment? Sitting-based mindfulness practices are one path. Yoga provides another way. In Kundalini yoga, we move the body and breath and apply the technology of the sound current. The mind-body links are thus used to prepare the mind for meditation. All eight limbs of yoga are present in every Kundalini yoga class. Asana, or posture, is just one of these limbs. I love practicing and teaching Kundalini yoga because it is fast and effective, getting us into the "zone," even after a few minutes. Because posture is not the sole emphasis, this form of yoga can be taught to anyone, no matter the state of the physical body.

There are many ways to find one's meditative mind. For some, it may be walks in nature or any calming, rhythmic activity, such as walking, jogging or kayaking. It may be a meaningful hobby, such as creating art or music. When we take the time to relax the mind, to listen, to be truly ourselves on our deepest level, then we bring that awareness into everything that we do. Including patient care. Including the time that we spend behind the wheel of a car. Including how we relate with our loved ones. From that solid core, we are less likely to do harm to ourselves or to others. Mindfulness saves lives.

Hari-Kirin Kaur Khalsa, M.D., aka Diane Pingeton, volunteer faculty, Department of Obstetrics & Gynecology, UMass Memorial Health Care, is currently focused on the intersection between western health care and yogic technology. She serves as the interim yoga center director at Yoga at the Ashram in Millis and as faculty in the yoga therapy training program of the Guru Ram Das Center for Medicine and Humanology in New Mexico. She and her colleagues offer classes by donation via Kundalini Yoga for All-Worcester. She may be reached at info@yogaattheashram.org.

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On Suffering

Sara-Grace Reynolds, M.D.



Vipassana meditation, the basis for mindfulness meditation, means literally “Seeing things as they really are.”

As an intern, things are tough.

At times, unbearable may be the more accurate descriptor.

The first year of medical training feels, most of the time, like an obstacle course of dodging and ducking and bobbing and weaving my way through this thing called life.

Sara-Grace Reynolds, M.D.

There is so much suffering around us in the medical profession. It is impossible to

have your eyes open and not see it. I think many of us simply turn away because it is too much. To feel deeply is a blessing and a curse. Recent studies have brought light to the staggering rates of depression among medical residents. I am certain that those of us who are sensitive suffer more.

We absorb the suffering of those around us – our patients, our colleagues, our superiors, many of whom are suffering from their own burnout and depression.

We may feel powerless to end our own suffering, let alone heal the suffering of others.

The Buddha told us that “Life is suffering.” The idea of suffering is not intended to mean that all of life is bad, but rather, it is a practical commentary on the world as it is. The Buddha outlines in his teachings the ways to end suffering by seeing things as they are. Seeking, and someday seeing, the truth. Ultimately, the nature of suffering is determined by how one responds to it.

Many of us cling to suffering. We sit in anger; we hold grudges; we suffer more.

The yoga sutras also spell out that past suffering cannot be avoided, but future suffering can, and should, be avoided.

What is the key to end this suffering, you ask? How do we learn to see things as they really are?

Reflection. Intention in loving kindness and non-violence in all things.

Towards others and towards ourselves.

I get it. It is a battle to bathe myself some days, let alone reflect.

The irony is not lost on me, as I sit here, sleep-deprived, writing on mindfulness.

I was incredibly lucky to be able to spend a year away from training as a fifth-year medical student to cultivate a shift in perspective. I learned to meditate. There have been times in my life where I have meditated a lot. I have experienced stillness. Briefly, but completely, at times.

In meditation, there is a deep connection to the universe and to all people and things that exist in it. It is the perfect complement, and equally the antithesis, of the dehumanizing effect that medicine can have.

In more recent times, the chaotic hum of the hospital has infiltrated even my dreaming mind. It is hard to let go of. Somewhere, though, in between the chaos, the peace frequency is there. I know it is. It is simply a matter of tuning in to the vibration.

If you tune in, with practice, you will feel the vibrating undercurrent of the universe; all the bad things and the sad things and the beautiful things humming to you at once. The truth becomes apparent. It will all be ok. It won't, and it will, and that is OK.

There are horrible wrongs that we see every day that we are utterly powerless to fix.

And it is sad.

And that is OK.

There are moments of beauty and wonder and hilarity, too.

There is something my teacher calls “equanimity mind.” In brief, it means that we need not always react. To both joy and pain. We may, with practice, be able to just observe things as they are.

This is a skill that can be learned.

Going inside our own mind is the first step.

Incorporating meditation (or mindfulness) into your life

The 5-to-15-minutes-a-day resident (and attending!) friendly plan.

Outlined below are a few brief five-minute beginner meditations. You can combine any of these techniques together or spend more time on them, as you like.

Sit in a quiet place. I often sit in bed just before going to sleep when the day has been busy. In most traditional schools of meditation, you should not lie down while meditating to prevent sleepiness. If you are trying to improve your sleeping and are practicing just before bed, by all means you can lie down for these techniques.

Technique 1: Set a daily intention

Take a few deep breaths.

If you are struggling to tap in mentally, try to practice this basic breath retention technique for about five cycles of breath or as long as you like.

Basic pranayama (breath control) technique:

- Inhale through the nose for four counts, as slow as you are comfortably able.
- Hold breath in for four counts.
- Exhale through the nose for four counts.
- Hold breath out for four counts.
- Continue for about five cycles, then relax. If holding the breath out is too challenging, just cut out that step. If you feel the need to sigh, let it out!

Cultivate an intention (sankalpa)

Sankalpa means conception or idea or notion formed in the heart or mind, a solemn vow or determination to perform, desire, definite intention, volition or will.

What comes to you? What do you want to cultivate?

Peace in your heart?

Gratitude?

Forgiveness?

Acceptance?

Sankalpa can be anything at all.

Allow yourself to focus between your eyebrows at Ajna Chakra, or the third eye, the eye of wisdom. Allow your intention to bloom. Sit here as long as you can stay focused on your intention. Even if it is just a few breaths, that it OK.

Eventually, you may put your intention in the present tense. Instead of “I will be grateful,” it would be “I am grateful.”

Technique 2: Anchoring to breath or sound awareness

Variation A

Try to guide your awareness to your breath. If you have not practiced this before, it may be very challenging. Pick a place to hold your focus that feels most natural to you. This is referred to as an “anchor” in some types of meditation. Perhaps the nostrils, the throat, the chest or the belly feels most comfortable. When your mind drifts off, kindly guide the attention back to your breath. This will happen many times. There is no need to feel frustrated if your mind is drifting, this is the nature of the mind. Eventually, you may become “thoughtless” and no longer be focused on the breath. This is OK.

Variation B

Similar idea, but allow sounds to be your anchor. Simply sit quietly and open your ears fully to sounds. Allow yourself to be the undisturbed observer of the sounds. No need to react.

Sometimes I like to focus on breath, sometimes sounds, sometimes both.

You can spend five minutes or five months sitting like this.

Technique 3: Metta Sutta – loving kindness meditation

Recite this mantra to yourself, out loud or mentally, as many times as you like.

May I be safe.

May I be happy and know the true causes for happiness.

May I be healthy.

May I be free from suffering, mental or physical.

May I be kind.

May I live a life of ease of well-being.

Some people have great difficulty initially wishing loving kindness on themselves. Pick a loved person or a pet to start with if you are struggling. Work up to reciting for yourself.

You may recite this mantra for others you care about. Eventually, you may recite it for people you have difficulties with. You may even eventually recite it for the whole world.

This is abridged from the complete *Buddhist Metta Sutta*, which is unbelievably beautiful. Please seek it out if you are curious.

Sara-Grace Reynolds, M.D., is an internal medicine intern at St. Vincent Hospital in Worcester. She is going into physical medicine and rehabilitation and plans to practice integrative pain medicine. She is a 500-hour certified yoga teacher and teaches at Metrowest Yoga in Worcester. She has studied yoga and meditation locally and in two trips to India.

Mindfulness in Psychiatry Program and Emerging Initiatives at the University of Massachusetts & UMass Memorial Health Care

Makenzie Tonelli, BA; Carl Fulwiler, M.D., Ph. D.; Fernando de Torrijos, M-CTTS; Douglas Ziedonis, M.D., MPH

Mindfulness is moving into mainstream vocabulary in health care settings. This centuries-old wisdom has gained increasing popularity and empirical support for its effectiveness in stress reduction and helping mental health and medical conditions. With clinician burnout rates rising, leaders recognize the need to enhance resiliency in a rapidly changing, high-stress environment. Mindfulness – a state of mind that emerges through cultivating nonjudgmental, compassionate awareness of the present moment – helps increase presence, focus and clarity in moments of uncertainty and distress.

More physicians and other clinicians are seeking mindfulness training to enhance their own well-being, clinical practice and leadership.¹ This article describes one group's experience in successfully supporting and integrating mindfulness activities and training. The Department of Psychiatry at the University of Massachusetts Medical School (UMMS)/UMass Memorial Health Care (UMMHC) is a large department of more than 360 faculty (mostly physicians and psychologists) supported by more than 2,000 staff in clinical, teaching and research work. About eight years ago, Chairman Doug Ziedonis, other department leaders and many from the front lines began sharing about their common interests in mindfulness.

The group recognized the unique and valuable opportunity to receive support and training at the UMMS Center for Mindfulness (CFM), where the Mindfulness Based Stress Reduction (MBSR) approach was developed in 1979 by its founder and pioneer, Dr. Jon Kabat-Zinn. The CFM is the global leader in MBSR training and certifying MBSR teachers. The CFM provides MBSR and other related services.² Recognizing CFM as a premier resource, globally and in this community, the department has benefitted from the support and experience of the CFM leaders, staff and resources.

The department established the Mindfulness in Psychiatry (MIP) Program in 2008, with the aim of improving patient care, providing support and an initial introduction to interested members of the department, and expanding research in mindfulness. A strategic plan was established with short- and long-term goals and activities to integrate mindfulness into all mission areas, including leadership development, team building and employee wellness. Faculty interested in mindfulness developed a Mindfulness Academic Interest Group (jointly with CFM), which supports their interests and explorations. The department invested in some faculty and staff leaders to begin to lead and coordinate the MIP. Senior MBSR teacher, Fernando de Torrijos, helped develop the program's initial activities and became director of the MIP. In the past year, Makenzie Tonelli began coordinating the program, and the activities continue to expand.

Clinical Applications

Mindfulness-based interventions (MBIs), including MBSR, are effective in helping many mental health and medical conditions. Many psychiatry clinicians have attended the CFM's MBSR program for themselves, developed a personal mindfulness practice, expanded their learning with MBCT or other MBI trainings, and integrated the principles into their work, including in many outpatient and inpatient psychiatry clinical programs. One example of this work has been described in a 2014 article on implementing mindfulness practices for staff in an adolescent psychiatric inpatient setting.³ This project was successful, and lessons were learned about organizational facilitators and barriers to teaching clinical providers in their work setting. After staff training, the focus shifted to bringing mindfulness to the adolescent patients. Other mindfulness-based behavioral therapies, such as MBCT, Acceptance and Commitment Therapy and Mindfulness-Based Relapse Prevention, have now been introduced. In addition, the patient Wellness Initiative in Psychiatry includes mindfulness, stress reduction, smoking cessation, weight management and sleep hygiene.

Research and Innovations

Many department faculty and affiliates are conducting mindfulness-related research (e.g., behavioral therapy, multi-cultural, neuro-imaging studies, etc.) focused on evaluating MBIs in a variety of mental health and addiction treatment populations, including for depression, anxiety, obesity and pain management. Various research team meetings are held for increasing collaboration and mentoring new faculty.

Educational and Leadership Development

In addition to referrals to CFM's training programs, the department now offers a range of other professional training opportunities for clinicians, educators and trainees. These opportunities range from small exposure to group meditative pauses at monthly department meetings to intensive trainings, informal meetings and support groups for integrating mindfulness at work, medical student electives, workshops and conferences. Dr. Ziedonis continues to have support from The Physicians Foundation to develop and implement the Mindful Physician Leadership Program, which has been well received by physicians across the state of Massachusetts with limited mindfulness experience. This program will now be expanded to have an advanced track for prior participants and a track for those new to mindfulness, desiring to help their life, clinical practice and leadership.

Employee Wellness Community Practice Opportunities

Faculty, staff and trainees have opportunities for at-work support in developing personal mindfulness practices by attending weekly drop-in meditations. A formal practice is important groundwork for integrating mindfulness into their work and also for promoting personal well-being.

UMass-Worcester Campus-wide Vision: Mindfulness in Medicine and Clinician Wellness

There are now UMMS/UMMHC campus-wide initiatives supporting mindfulness integration, which provides support to the whole campus from which the Department of Psychiatry members also benefit. The CEO of UMMHC, chancellor at UMass Worcester and other UMass leaders have recognized the value of mindfulness for patients, staff and providers and are supporting these newer system-wide initiatives. This Mindfulness in Medicine initiative, led by Carl Fulwiler, associate professor of Psychiatry and Medicine and medical director and associate research director at CFM, offers opportunities for employees to practice mindfulness at weekly drop-in meditation sessions, attend provider CME events and join champion training opportunities. Champions encourage employees to take initiative in introducing the practice to their colleagues within their own sub-specialties and teams. The initiative has developed mindfulness videos and other resources for UMMHC patients, and clinicians are encouraged to inform patients about this information. Additionally, the Clinician Wellness Program, with its new director, Carl Fulwiler, is developing mindfulness-based programs to support and promote physician well-being and resilience.

In summary, the UMMS CFM is a great resource for our community and is leading the recent UMMHC/UMMS campus-wide mindfulness initiatives. The Department of Psychiatry has benefited from this context and continues to expand the MIP initiatives.

***Makenzie Tonelli, BA**, is project coordinator for the Mindful in Psychiatry Program in the Department of Psychiatry, University of Massachusetts Medical School. **Carl Fulwiler, M.D., Ph.D.**, is an associate professor of Psychiatry and Medicine and the medical director and associate research director at the Center for Mindfulness in Medicine, Health Care and Society, University of Massachusetts Medical School. **Fernando de Torrijos, M-CTTS**, is a senior Mindfulness-Based Stress Reduction (MBSR) and Mindfulness-Based Cognitive Therapy (MBCT) teacher and the former director of the Mindfulness in Psychiatry Program, University of Massachusetts Medical School. **Douglas Ziedonis, M.D., MPH**, is professor and chairman of Psychiatry, University of Massachusetts Medical School /UMass Memorial Health Care.*

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The Evolution of Integrative Therapies at HealthAlliance Hospital

Lynn M. Gerrits, MA



Lynn M. Gerrits, MA

My husband is a cancer survivor; 10 years in June. Tonsil cancer.

Our boys were 10 and 12 when he was diagnosed. Talk about a curveball. He was never sick, played basketball twice a week and didn't meet any of the criteria for squamous cell carcinoma. A curveball. That's how cancer hits you. It knocks your world off its axis and sends it spinning out of control.

At the time, I was working as a fee-for-service mental health clinician through agencies, which in retrospect, allowed me to be available to my family. It quickly became clear that my skill set in stress management techniques and holistic practices prepared me and our family fairly well to manage aspects of this journey. We at least had some control over how we went about managing and relieving the effects of stress, and the feeling of empowerment in this regard went a long way.

However, I also remember how frustrated we were with how many different medications he was prescribed to manage the side effects of treatment – and then more to manage those! Because he was a head and neck patient going through a tough course of concurrent chemoradiation, the

side effects mounted quickly – nausea, diarrhea or constipation, dry mouth and mucositis, pain – and they were all “managed” by meds. Back then, we didn't have options to manage the side effects. Therefore, we focused our efforts on managing our stress by using breathing and relaxation techniques, music and guided imagery, and I often gave him foot massages and Reiki to help him sleep. Little did we know, a few years later, he would have had a plethora of options to actually reduce those awful side effects, even the mucositis!

As my husband's caregiver, two things were clear: 1) a person is so much more than his/her disease, as the body is not the only thing impacted by the disease; 2) having options can lead to feeling empowered in one's own care.

Ironically, in 2010, a serendipitous series of events presented the opportunity to manage the newly opened Simonds-Hurd Complementary Care Center at HealthAlliance Hospital, right below the cancer center where my husband had received radiation treatment four years earlier. The center is open to the public for therapeutic classes or services that support the body's innate ability to heal, including massage, Reiki, acupuncture, yoga, fitness classes, etc. Its mission is to provide complementary therapies that are noninvasive, nonpharmacologic adjuncts to mainstream medical care, not to be used as a substitute. Research has shown these therapies can improve patients' strength and control of the physical and emotional symptoms associated with disease management and result in an enhanced sense of well-being. Its ideal location, directly beneath the Simonds-Hurd Cancer Center, created an opportunity to finally offer some of those healing services to the patients as they underwent treatment.

Reiki, which is a very gentle, noninvasive, spiritual healing practice involving light touch that evokes a measurable relaxation response, was the first service to be introduced via a volunteer program in 2011. Patients and caregivers alike are invited to participate in this relaxation technique, which is subtle and nonmanipulative. Staff will often ask a volunteer to offer Reiki to a patient who is nervous about an IV start or a new medicine known to elicit a possible “reaction.” On a number of occasions, it has also been made available to patients before, during and after a bone marrow biopsy, with significant results in decreasing patient anxiety. Reiki is now in its fifth year in the cancer center, where it continues to be offered at least twice a week, and in its third

year on the inpatient side of the hospital.

In 2012, after being awarded a grant from Angie's Spa Cancer Foundation, patients and caregivers have access to free services, including hand/foot/chair massage, acupuncture, yoga and, most recently, a certified music practitioner who plays the keyboard or harp. To date, our practitioners have provided more than 3,000 massages, 1,400 acupuncture sessions and 600 yoga sessions. These therapies are safe, evidence-based practices delivered by trained and licensed practitioners. Patients are referred for therapies or request them on their own. Patient feedback, utilization management, staff and provider observations and testimonials are used to evaluate the effectiveness of the therapies. Based on these results, therapies have been shown to reduce physical symptoms and improve emotional wellness and quality of life. Given these findings, there is promise in demonstrating the value that these therapies bring to traditional medical care, and at HealthAlliance, they have become an integral part of overall cancer care.

This comprehensive approach to cancer care, from diagnosis through survivorship, benefits residents in surrounding communities who have access to excellent, whole-person care close to home. A multidisciplinary team that resides within the cancer center allows providers to identify patients who might need services sooner than later (i.e., head and neck patients can be referred to acupuncture before starting radiation to help prevent the onset of xerostomia). In addition, the medical team observes the benefits patients receive from services and communicates directly with providers about patient care, potential contraindications (though there are few), etc.

Not surprisingly, the success of complementary therapies in the cancer center led to other departments expressing interest in developing similar programs, including the establishment of nursing competencies in a variety of relaxation techniques, such as hand massage and aromatherapy. There is also unique program to provide nonpharmacologic soothing measures to NAS babies, as well as therapeutic supports, such as stress management skills, to their moms pre- and post-natally. Integrating services with palliative care, as well as establishing options for pain management, are also in discussion.

Providing quality health care to our patients should include an integrated approach that is empowering, compassionate and gives patients new tools to be responsible for their own optimal health and well-being. Even though my husband was not able to utilize these services during his care, he is happy knowing that others now can.

Lynn Gerrits, MA, is manager of the Simonds-Hurd Complementary Care Center at UMass Memorial - HealthAlliance Hospital in Fitchburg.



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Introduction: The 2016 Creative Writing Exposition

Robert Sorrenti, M.D.

Once again, *Worcester Medicine* has agreed to publish the blue-ribbon entries in the Creative Writing Exposition of the Massachusetts Medical Society (MMS) Arts, History, Humanism & Culture Member Interest Network (Arts MINS). The Arts MINS is a standing committee of the MMS, which provides a forum for members to explore, develop and participate in non-medical activities. These activities have ranged from bird-watching to bonsai-planting, from art exhibitions to astronomical viewing and include sponsorship of the Creative Writing Exposition.

Held about every other year, the Creative Writing Exposition invites members of the medical society to submit personal works of prose or poetry. The entries are evaluated by a panel, and those judged to be “blue ribbon” are printed in *Worcester Medicine*. This year, we had a number of entries, including works of fiction and non-fiction, as well as various forms of poetry. We appreciate the participation of all the authors in this exposition.

We know how busy doctors can be. This exposition highlights what some of our physicians do in their spare time. The entries being published in *Worcester Medicine* provide a glimpse into the personal lives of three physician authors. I hope you enjoy reading these pieces and join me in thanking the authors for sharing their thoughts with us.

In closing, let me invite MMS and MMS Alliance members to take part in some of the activities and events the Arts MIN sponsors and to join us on the executive council to promote new areas of interest.

Robert Sorrenti, M.D., is the chairman of the Massachusetts Medical Society Arts, History, Humanism & Culture Member Interest Network (ARTS MIN).

Snow and Multiple Sclerosis

Alexander White, M.D., M.S.

We came to Boston on a hot day in June 1987. My wife had reluctantly agreed to move to the U.S. for two years only – not a day more – to indulge my craving for some foreign medical training. Then, we were headed back home to Ireland to live happily ever after. Life, of course, had different plans for us. My wife fell in love with Boston, got herself a cool job, and our son became a Red Sox fan in elementary school. In 1996, when our daughter arrived, we knew we were not going anywhere.

So, here we are in Boston in 2015. We consider ourselves privileged to live in the greatest American city.

So, what’s with “Snow and Multiple Sclerosis”?

Ireland never gets a lot of snow. The mild climate relates to the North Atlantic Drift, which keeps Ireland from freezing in the winter. I do remember two distinct snowfalls in my 29 years in Dublin. Once the snow arrived, life in the city ground to a halt. The schools closed, the buses stopped running, and the army was called in to shovel sand onto the main roads. The side streets and footpaths (sorry, sidewalks) were ignored, and everyone complained. The pubs, as always, did just fine.

Snow, on the other hand, is a regular winter visitor to Boston. We quickly learned that it has to be a really bad blizzard to bring Boston to its knees. The infamous blizzard of ’78 seems to hang in the air over Boston like some ancient Sword of Damocles and always comes up in conversation. We learned about snow shovels and the need to shovel the sidewalk outside your home. We cleaned the snow off the roof of the car after being blinded a few times when it all slid forward when braking on the Mass Pike. We learned the

downside of hiring someone to shovel and plough your driveway (it's expensive, and they show up too late to help you get out of the driveway to get to work) and finally figured out that a powerful snowblower is worth the expense.

We eventually slept through the reassuring scraping and rumbling of the snow ploughs at night as they cleared the streets for the morning commute. Within a few years, we had adapted to the annual New England meteorological drama, and it became part of our new life in Boston. We were able to reassure anxious relatives who called us on the phone that all was well, despite the dramatic scenes of polar desolation in Boston that would show up on the 6 o'clock evening news in Dublin.

What has any of this got to do with Multiple Sclerosis (MS)? MS is that enigmatic neurological disease that hits young people in the prime of life. Just when my wife was hitting her mental and physical stride in her late 20s, raising a son, working full time, BAM ... MS appeared. We were still in Ireland when she had her first attack, but like the Irish snow, it did not last. That first attack came at a tricky time for us. Our son had just arrived on the scene, and we were planning the move to Boston.

"Don't go," our parents pleaded. "Stay here in Dublin. It will be easier."

We went anyway because both of us are pigheaded and believed we could handle anything. Not bad character traits to have, as things turned out. At eight months of age, our son had no input into the decision. Our new daughter-in-law is happy he made the trip!

Like the snowstorms in New England, the MS attacks my wife experienced were much more severe, compared to the earlier mild event in Ireland. I watched the strain on her face and also sensed a new strain on our family life as she lurched from attack to attack. We had entered the frightening world of chronic, unpredictable neurological disease that included new hopeful drugs that she injected daily, rounds of chemotherapy that pushed her into premature menopause but controlled her disease for many years, ambulance rides to emergency rooms followed by stays in Boston hospitals and long stays in rehab. We had to learn how to deal with the blasts of MS while at the same time working, raising two children and trying to stay sane, miles from all family support.

Like dealing with the weather, we learned, as a family, to cope with the MS. As a husband and father, I had a lot to learn. Dealing with MS is like going through the five stages of grief in fast-forward. It's hard to deny what is staring you in the face. Anger was very real for both of us. This new life was not what we had planned; we were supposed to be living happily ever after, not figuring out whether my wife could work, whether we could or should have more children, whether I should quit my academic job for a better paid (and much needed) different job to deal with the financial impact of the MS blizzard that was raging in our home. I was angry with myself for being angry at my wife, who was angry at me for being ridiculously angry with her because she had MS!

There is not much bargaining to be done with MS. It just kept throwing us one neurological hand grenade after another, like some Machiavellian pitcher who knows and anticipates your every move and will strike you out, no matter what.

Depression for both of us was very real. My wife got great help and finally wrestled that devious monster to the ground and into submission. I struggled at work and at home with a toxic combination of anger and depression, and finally, with the help of family, great friends and supportive work colleagues, emerged to a place of acceptance a few years behind my wife. We have developed a few good habits, habit being a great friend to every human who has to deal with life. I am a better, but still mediocre, cook; I can pinch hit as somewhat grumpy caregiver; I know when not to react; I make a mean cup of tea for my wife every morning and can prepare breakfast, read email and check the news on my iPad at almost the same time. I can get all the medications set up for the week in their little boxes in about 15 minutes. I am a master at running the ever-lengthening morning and the evening checklists. Thank God for checklists. I am a self-confessed workaholic in recovery who is learning to say "no" at work to things that will negatively impact the new life we have rebuilt.

Learning to cope with MS took a lot longer than learning to cope with snow. It remains a challenge, even after 15 years of "training." Now, we are much better equipped to deal with the intermittent neurological drama that MS sends our way. Marcus Aurelius, one of the Roman Stoic philosophers, talks about learning to win your freedom from life's problems with patience, honesty and humility. We need to learn how to find a "safe anchorage" in our mind whenever the storm of life is raging all around. You must find a way to replenish your mind, your inner strength and your marriage by having a perpetual clear spring that can clean itself of all the mud and troubles that life will send your way. Mr. Aurelius was a very smart man; he is well worth a read, as his wisdom still resonates in 2015.

We have emerged from the MS jungle to a place in life that is better. The vagaries of the New England weather are just part of our life now. We eat dinner by the fire while the blizzard rages outside, and I have fun with the snowblower the next day. Our two children, our daughter-in-law, along with family and friends, both here and across the Atlantic, pitch in and help when they can. Like the snow, a blast of MS will rattle our household from time to time, but we are tougher now. We are lucky to be surrounded by a long list of New Englanders who help us manage the MS monster. Wonderful neighbors, doctors, home health aids, carpenters, plumbers, electricians, folk who adapt and maintain vans for wheelchairs and home care companies. Occupational therapists to figure imaginative ways to solve problems, physical therapists who maintain muscle function, nurses, psychotherapists, UPS delivery truck drivers, helpful lawyers, understanding financial advisors, humane bosses who mentor and guide...the list goes on.

The white plaques of MS are a snowstorm on my wife's MRI. We can handle it, no matter what comes. Together.

The Gift You Take With You

Laura Prager, M.D.

I am a child psychiatrist who believes in giving gifts to my child and adolescent patients. I have given diaries to pre-teens who wanted a place to keep secrets and a make-your-own volcano kit to a little girl learning how to manage her colostomy bag. One young boy stated clearly that he didn't want a toy for his birthday – he wanted to make instant pudding and have it for a special snack. After some discussion with his parents, we did that. But most kids get a carefully chosen book: a collection of fairytales for the fifth-grader who once described her mother as a wicked witch; young adult reality fiction for the precocious middle-school girl who was afraid of her own imagination. After years of clinical practice, I am no longer afraid to stretch the frame of therapy and give a child a birthday or holiday gift to take home as food for thought and a reminder of the time that we spend together.

Should child psychiatrists give gifts to their patients? The topic has engendered more discussion and debate than research, but many child psychiatrists, particularly those who do psychodynamic psychotherapy, give inexpensive, developmentally appropriate gifts at holiday time and/or birthdays as building blocks of a therapeutic alliance. Gifts can prompt a child to talk about feelings that he has been avoiding or simply allow him to feel valued. Gifts can illuminate a child's internal conflict or become a "transitional object" for the child who needs a tangible reminder of the therapist in order to feel cared for. The gift itself is less important than the therapist's understanding of its meaning to the child and the child's ability to tolerate the feelings it engenders.

Perhaps my comfort level with gifts was strengthened by the fact that I was also once a child who received a gift from her therapist.

My parents, both child psychiatrists themselves, worried that I was a troubled first-grader who needed help managing the anger and resentment that emerged following the birth of two younger siblings in quick succession. (Maybe the winter evening that I stole a small, green, rubber unicorn from my best friend's shelf and walked home with it tucked into my boot tipped the scales?) As my mother had also chosen that time to return to part-time practice, our house was suddenly filled with babysitters. After four relatively quiet and happy years, in which my mother and I had been a team, I was now caught between two demanding siblings in diapers and the ministrations of well-meaning women who were not my mother.

From my current vantage point as both a child psychiatrist and a parent, I understand why the first thing that my parents did when they thought I was stumbling was ask a supervisor to do a consultation. My father chose Dr. D, who had herself been analyzed by Anna Freud and who was by that time a very senior child psychiatrist and child analyst. Like her famous mentors in Vienna, she saw private patients in the drawing room of her home. Would she be willing to evaluate Laura and treat her if necessary? Soon, I was holding my father's hand as we walked together up

the front steps to her home and entered Dr. D's "consulting room," which was furnished with thick, heavy armchairs in shades of red and matching, flowing, floor-to-ceiling drapery. It must have been winter, as there was a fire in the fireplace, with a small stool placed at a careful distance from it, which I assumed to be for me, although quite possibly it was meant for Dr. D to rest her feet.

As with the problems that brought me to her drawing room, I pruned the details of the treatment long ago. What I do recall is walking with Dr. D down a long, dark hallway to the kitchen in the back of the house where, magically, someone was always making chocolate chip cookies and I was lucky enough to get one. After several months, Dr. D told my parents that I was just fine – it was normal for a 6-year-old to be resentful of younger siblings who required time and attention; it was normal for a 6-year-old to be upset when her mother shifted some of her attention to pursuing her career. My parents were a bit embarrassed, I think, and my visits to Dr. D's parlor ended.

Some would consider the therapy sessions as a kind of gift, and I have no doubt that they were. Others would count the cookies as a gift – a nourishing, warm, delicious treat to counter whatever deprivation I might have been feeling due to my mother's changed role at home. But Dr. D took gift-giving one step further. At our final session, she gave me a picture book first published in 1939, written by Du Bos Heyward and illustrated by Marjorie Flack, titled *The Country Bunny and the Little Gold Shoes*.

The book is about a young female bunny who dreams of glory, but who grows up, gets married and stays at home to raise a large brood until elder statesmen bunnies choose her for an important job that requires her to leave home. She had raised her children so well that they were able to manage just fine in her absence and even were willing to share their mother's attention with others who needed her in a different way. The illustrations convey the sheer enormity of the distance that mother bunny had to travel to deliver a special ornate Easter egg to a child who was desperately ill and the satisfaction that mother bunny's children derive from managing the household while she was gone.

I carried my gift home and put it on the bookshelf in my room where, over the years, I glanced at it occasionally but rarely opened it. When I was old enough to understand such things, I noticed that Heyward's book was an Easter story. As my family didn't celebrate Easter, I wondered briefly why the elderly "talking doctor" with the chocolate chip cookies had given it to me. Yet, when I finally moved out of my childhood room after college, I packed it in the box of mementos that I took with me from place to place for reasons that I didn't really comprehend.

In retrospect, the story's parallels with my own childhood are as vivid as the colors of the Easter eggs themselves. A young woman postpones her dream of a career helping others in order to raise a

family, only to attain a place usually reserved for men and resume her quest when her children are old enough to manage without her. It's difficult not to admire mother bunny's ambition and accomplishments. After a shaky start, she became both a devoted, caring mother and a compassionate caregiver to sick children.

Was that what Dr. D was trying to say? Was she telling me that I should admire my mother rather than resent her? Showing me another way to understand her choices and suggesting that I had the tools to manage some things on my own? By feeding me chocolate chip cookies and sending me home with a book, was Dr. D trying to help me accept some "mothering" from others and realize that I did not need my mother for absolutely everything? Or, was she trying to tell me something about what I should do with my own life, mapping out a future that I was, as yet, too young to understand? Yes, Laura, you feel powerless now, but you will grow up and be able to make your own way. You can do what you want to do, be who you want to be – even if you don't do

everything all at once.

I like to think that Dr. D meant all of those things. Just like my mother, I eventually went to medical school and started a psychiatry residency, leaving in the middle to raise children before returning to my training and launching my child psychiatry career. It was not until I opened *The Country Bunny and the Little Gold Shoes* to read to my own children and saw "To Laura from Dr. D" inscribed on the title page that I remembered the curtained parlor, the enveloping warmth of the fireplace, the child-sized footstool and the lingering aroma of freshly baked cookies. The gift I took with me conjured up all the intangible gifts I have received from those who have loved me and cared for me, the gifts that have enabled me to continue giving.

Laura M. Prager, M.D., is associate professor of Psychiatry at Harvard Medical School, director of Child Psychiatry Emergency Service at Massachusetts General Hospital and director of the Transitional Age Youth Clinic at Massachusetts General Hospital.

The Biopsy Results Are In

Robin Schoenthaler, M.D.

"What do people say?" strangers always ask, after I tell them what I do for a living, "When you tell someone they have cancer, what do people do?"

I try to tell them it is usually quieter than you might expect. Sometimes there's a wry hands-on-hips moment, a flush of righteousness, the old tombstone epitaph joke: "See, I told you I was sick." For one long second, there's something like a lightning strike of relief: I knew it, I told my sister, I was *sure* something was wrong. And then hands slide down the lap and then join.

Once in a while, there might be disbelieving questions about lab error, or mixing of results, or operating on the wrong patient, or the wrong name on the label; it's not far-fetched; they read about it in a magazine. In the waiting room just a few minutes ago before this line was crossed.

And sometimes there is the backstep, a flash of "It's my turn." A slow closing of eyes, a nodding of the head or an unblinking gaze: I've watched people line up for this parade for decades now, and now

they're calling my name. Who's on first? Good god in heaven, I'm on first.

I try to tell strangers: An exam room isn't like a soap opera, or a movie, there is no narrative arc or climactic scene. Almost nobody slides off a chair, and only once a year or so is there the kind of scream that shrieks through the door out to the waiting room where people sit paralyzed with *People* magazines pulled taut.

Most reactions, at least in our village, mostly, are quiet, steady, even. People say, "Oh my god" or "Really?" or "I was afraid of that." They look down at their hands but then back up. Their mouths open and close and they say "Oh."

I try to tell strangers: There's a lot of "Oh's" in my cancer clinic. Some with finger curling. And then the wonder, aloud, eyes of deepest hue "What am I going to tell the kids?" while pupils get smaller and then big as the night.

Privacy Breaches and Invasions

Peter J. Martin, Esq.



Peter J. Martin, Esq.

Health care practitioners have for years known that, under HIPAA, if there is a “breach” of unsecured, protected health information, there may be an obligation to notify the affected patients or regulatory agencies or both. Likewise, under Massachusetts data privacy laws, there are well-known notification obligations in the event of a breach of security with respect to personal information. Regulatory guidance exists to help practitioners understand when a “breach” has occurred – under HIPAA, the breach has to compromise the security or privacy of the information; and under state law, the breach must

create a substantial risk of identity theft or fraud.

A recent Massachusetts Superior Court case has highlighted another legal avenue for those aggrieved by an unauthorized disclosure of confidential information, this time under the state right of privacy statute: Massachusetts General Laws, chapter 214, section 1B. That statute says, “A person shall have a right against unreasonable, substantial or serious interference with his privacy.” In a decision handed down in November of 2015, the court permitted a claim to proceed under that statute, brought by a group of hospital patients whose medical records were inadvertently posted on a website, denying a hospital’s motion to dismiss the case. The decision is based on the Massachusetts law of “standing” – basically, the rule that a plaintiff must allege at least a real and immediate risk of injury in order to bring a claim. Here, the court ruled that since plaintiffs alleged facts that, if true, “suggest a real risk of harm from the data breach,” the case should not be dismissed but should proceed so as to allow the development of further evidence regarding whether the data was accessed and, if so, the nature and extent of that access.

The dispute began when the hospital sent notices to the affected patients that their patient records “were inadvertently made accessible to the public through an independent medical record transcription service’s online site.” The hospital also advised those patients that the medical records “could potentially be accessed by non-authorized individuals,” though the hospital did not know how long the information was available or whether any of it was misused. In so doing, the hospital appears to have met its HIPAA obligation of providing affected patients a description of the breach incident itself and the types of information affected by it.

The patient-plaintiffs read this notice and inferred that their records were accessed or were likely to be accessed by unauthorized persons. They sought damages against the hospital and the medical transcription company for the unauthorized exposure of their medical records. The first count in their complaint was for “invasion of privacy” under the Massachusetts privacy statute. The court ruled that the plaintiffs’ allegation of a risk of harm was sufficient to survive the defendants’ motion to dismiss the case. The defendants claimed that without an allegation that the records were actually accessed or used by an unauthorized person, the plaintiffs had failed to state a claim. The court disagreed. The plaintiffs thus were not required to allege that unauthorized persons actually accessed or misused their information to proceed with their case.

There are a couple of comments to be made about this matter. First, note that the standing threshold in this case is that the plaintiffs allege facts that support an inference of there being a “real risk of harm from the data breach.” The level of risk does not need to be quantified, though the alleged injury may not be speculative, remote or indirect. While the plaintiffs may, at a later stage in the trial, be unable to show actual harm, the court’s reasoning suggests they might still recover damages if, for example, they can prove mental distress or harm to their interest in privacy arising from the information being made accessible, perhaps even in the absence of actual misuse of the information. In contrast, under HIPAA, an “acquisition, access, use or disclosure of protected health information” is only a “breach” giving rise to notice obligations if the breach “poses a *significant* risk of financial, reputational or other harm to the individual” (emphasis added). Further proceedings in the case may lead to the result that access to redress under Massachusetts’ privacy statute is easier to come by than under HIPAA.

Second, it appears the court found it significant that the hospital was unable to say how long the information was publicly accessible through the website. The court said that the plaintiffs reasonably inferred both that this accessibility lead to a serious risk of disclosure and that the records either were accessed or were likely to be accessed by an unauthorized person. It appears the court felt that the longer the period of such accessibility, the stronger those inferences could be drawn. Consequently, practitioners and health care institutions are well advised to seek to identify and rectify an unauthorized disclosure of information as soon as possible so as to weaken those inferences, and thus, the potential for a successful claim for damages.

While still at an early stage, this case is worth monitoring, as it may result in the expanded use by patients of the Massachusetts privacy statute to seek remedies for “breaches” of health care information security or “invasions” of health care information privacy.

Peter J. Martin, Esquire, is a partner in the Worcester office of Bowditch & Dewey, LLP, his practice concentrating on health care and nonprofit law.



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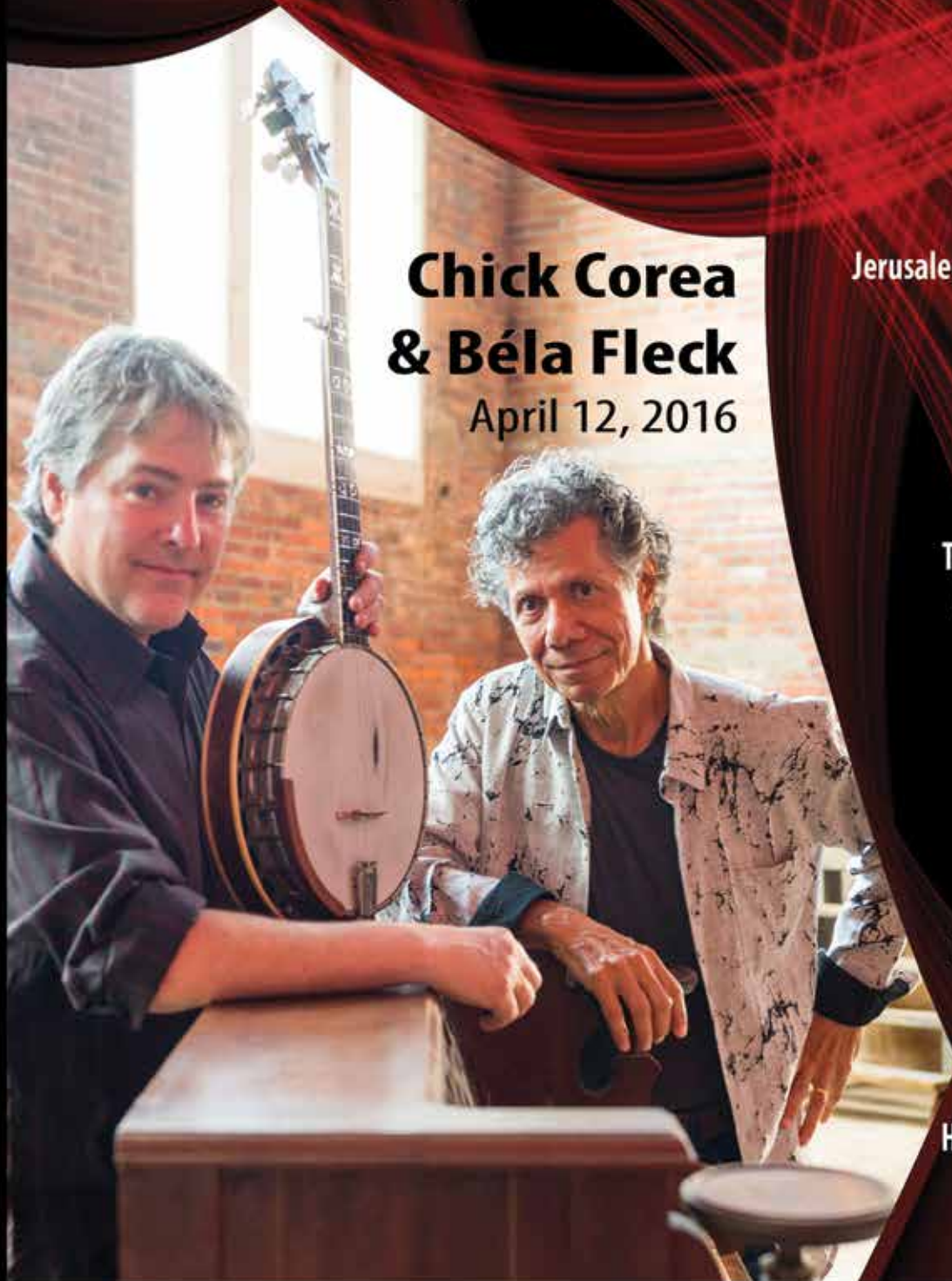
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WARREN J. FERGUSON, M.D.

Dr. Ferguson, is vice chairman of the Department of Family Medicine and Community Health at the University of Massachusetts Medical School, a professor in the Department and medical director of the school's Massachusetts Area Health Education Centers (AHEC) Network. He will be presented with the 2016 Community Clinician of the Year Award at the Annual Business Meeting on April 13.

The Community Clinician of the Year Award was adopted at the Interim House of Delegates meeting in November 1998. It was established to recognize a practitioner from each district medical society who has made significant contributions to patients and the community.

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Our history is vital to our future. Join us as we listen to the stories and let the lives of our colleagues become a part of us.

Samuel Claude Zwemer Pickens, M.D.

March 12, 1927-August 1, 2015

Husband, father, physician, teacher, mentor, colleague, friend, patient, community leader and humble servant. In all these roles, Sam Pickens left an indelible mark on this community.

When I met Sam in 1975, he had already accomplished more than most do in a lifetime. Son of missionaries in Nanking, China, his family was transported halfway around the world during World War II and exchanged for Japanese nationals in Lourenco Marques (now Maputo, the capital of Mozambique). He finished his education in the U.S., interrupting his college studies to join the war, despite being underage. He continued his education at Hope College and received his M.D. from Wayne State University.

After an internship, he was a general surgery resident at Memorial Hospital, where he became chief resident and met and married his wife Florence (Sandy), a nurse. They followed his roots, serving as missionaries in south India. Desiring additional training in orthopedics to better care for patients suffering from leprosy, Sam returned to Boston City Hospital for an orthopedic fellowship, then spent 13 years restoring movement and eyesight to leprosy sufferers in places like Ramanathapuram, Madurai and the Palghat Gap.

In 1973, Sam returned to Barre as physician/teacher and then medical director of the new Barre Family Health Center. Learners came to know him as a stern, warm and compassionate physician/teacher who stopped at nothing for his patients, expecting the same of his residents. His vision for comprehensive care in service to the community and exposing learners in family medicine to broad clinical experience continues to guide BFHC to this day. The careers of more than 150 family physicians trained by Sam are testimony to his success.

Dr. Pickens was a diplomate of the ABFM, a member of MAFP, AAFP, AMA, STFM and WDMS; an associate professor of Family Medicine at UMass Medical School; and a member of the medical staff of UMassMemorial Healthcare. He received numerous awards in recognition of his work, including awards from WDMS, but respect for his deep humility demands that they not be highlighted.

Resigning as medical director in 1989 and retiring from clinical practice in 1996, Sam continued teaching until his death. A lifelong learner, he continued to help learners across generations become more caring physicians, always giving his undivided attention to the patient or learner at hand. He taught with good humor, an open heart, respect and admiration. He branded the Barre Way: humbly caring and serving the community.

Dr. Pickens served on the Quabbin School Committee, Barre Board of Health and the Board of the Barre Rescue Squad. He worked on food programs as a warden at All Saints Church, Worcester. He was an avid gardener, stamp collector and history buff who loved jazz and always saw the humor in life.

Dr. Pickens is survived by his wife, Sandy; their sons, Sam, John, James and Richard; six grandchildren, Andrew, Sam, Claire, Elliot, Ethan and Violet; his brother, Peter; and sister, Patricia.

– Stephen T. Earls, M.D.

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