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COMMUNICATION IN HEALTH CARE



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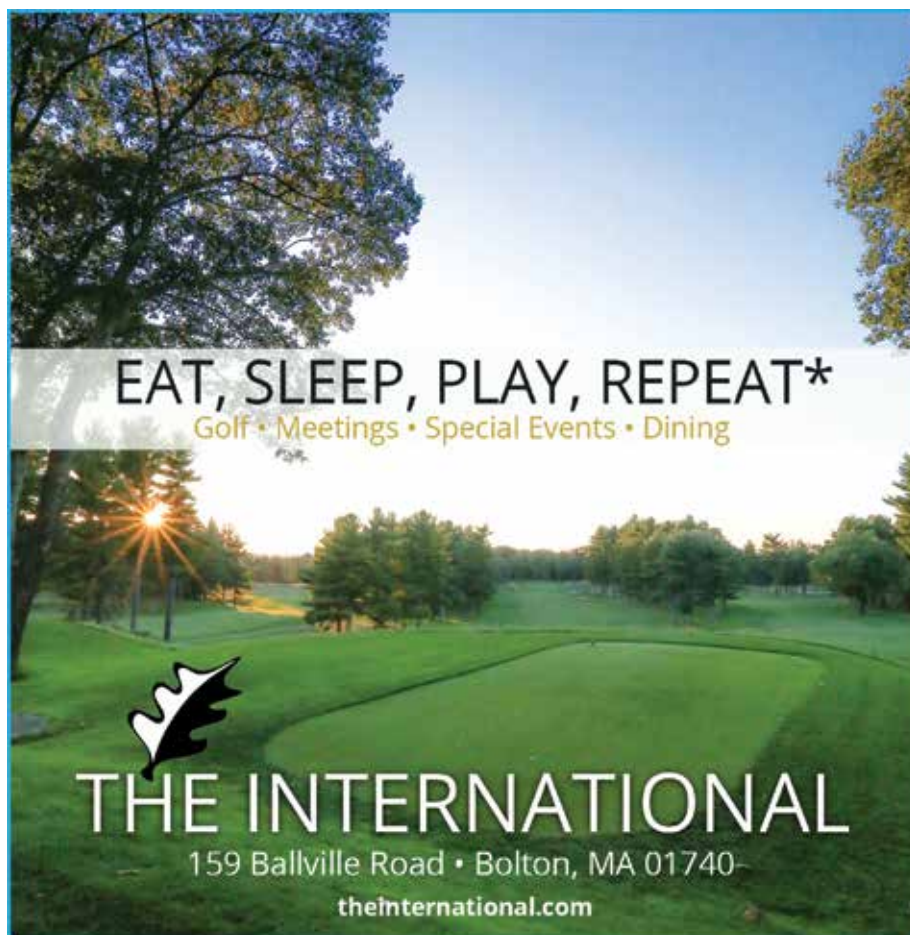
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contents

Vol. 80, No. 3

on the cover: communication in health care

- | | |
|---|---|
| <p>6 Editorial
Jane Lochrie, M.D.</p> <p>8 President's Message
Frederic Baker, M.D.</p> <p>10 The Physician and Patient Relationship: The Effect of Technology
Eric Alper, MD, FACP, SFHM, CPE</p> <p>11 Communication Skills Teaching at UMass Medical School: A Tradition of Excellence and Innovation
Michele Pugnaire, MD</p> <p>12 Communication, the 'Real' Root Cause
Kelly Chandley, BSN, CPHRM</p> <p>13 The Aftermath of Medical Errors – 2016
Randolph R. Peto, MD, MPH</p> <p>14 Integration of Communication in an Accelerated Doctor of Pharmacy Curriculum
Jennifer Donovan, PharmD, and Michael Malloy, PharmD</p> <p>15 Empathy in Medical Practice
Randall J. Morse, MD</p> <p>18 Listen Up: The Patient Interview From Student to Physician
Meegan Remillard, MPH</p> | <p>19 Legal Consult: The Future of Community Hospitals in Massachusetts
Peter J. Martin, Esq.</p> <p>20 As I See It: A UMass Student Perspective on Fostering Compassionate Care in our Community
James Doolin, BA</p> <p>21 As I See It: Worcester Department of Public Health Receives National Accreditation from the Public Health Accreditation
Frederic Baker, MD, and Joyce Cariglia</p> <p>22 As I See It: Scribonius Largus
Felipe Fernandez del Castillo</p> <p>24 Movie Review: Finishing the Game
Michael Hirsh, MD</p> <p>25 A Legend Retires – Harvey G. Clermont, MD
Jane Lochrie, MD</p> <p>26 Society Snippets: Annual Business Meeting</p> <p>28 In Memoriam: Arthur M. Pappas, MD
Eric W. Dickson, MD and Michael F. Collins, MD</p> |
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Editorial

Jane Lochrie, MD



Jane Lochrie, MD

Studies have shown that effective communication has been linked to increases in patient and physician satisfaction, more appropriate medical decisions, adherence to treatment plans and better health outcomes. Moreover, recent research has linked effective communication with a decrease in malpractice claims. While the idea that communication is a crucial part of medicine is not new, there has been an increased emphasis on this in medical education.

In 1999, the Association of American Medical School's Objectives Project mandated that all medical schools "ensure that,

before graduation, a student will have demonstrated ... the ability to communicate effectively, both orally and in writing, with patients, patients' families, colleagues, and others with whom physicians must exchange information in carrying out their responsibilities." Shortly thereafter, the National Board of Medical Examiners added a standardized patient test, part of which focuses on communication, to the United States Medical Licensing Examination. This issue of *Worcester Medicine* spotlights how the Worcester medical community is communicating.

In the first article, Dr. Alper describes the way the computer has revolutionized the manner in which we communicate with our patients and each other. Though it has streamlined workflow and improved patients' access to their own medical records, he cautions us to use it appropriately to keep patient information secure and be mindful that patients do not want their physician to be looking at the computer screen the entire visit.

The standardized patient program for teaching and assessing students' communication skills at the University of Massachusetts Medical School (UMMS) is described by Dr. Pugnnaire. With more than three decades of experience with this program, UMMS is a leader in the field of medical student communication skills. More recently, UMMS has adopted the "multiple mini-interview" program as part of the admissions criteria to assess students' communication and interpersonal skills, as well as their critical and ethical decision-making, self-awareness and professionalism.

The Disclosure, Apology and Offer Law is dissected by Kelly Chandley. The law is meant to encourage open, honest and clear communication between practitioners and patients who feel that they have been harmed.

Kelly opines that the root cause of many malpractice law suits is miscommunication. She suggests that all physicians practice intentional listening, take responsibility and work together to improve patient care.

Drs. Donovan and Malloy describe how the School of Pharmacy – Worcester/Manchester (SOP-W/M), Massachusetts College of Pharmacy and Health Science (MCPHS) is following the mandate from the Center for Advancement for Pharmacy Education (CAPE) to integrate communication horizontally and vertically into the pharmacy students' curriculum. Communication is taught and assessed in each professional year of the program. Students are expected to progress through a continuum of learning and be proficient when they graduate.

Physicians do not have much experience handling the repercussions of a medical error. Dr. Peto suggests that patients want to learn the facts expeditiously and what can be done to lessen the impact of the harm. They want someone to take responsibility and desire an apology. Finally, they want to know what the system is doing to prevent a similar problem. Many hospitals, group practices and insurers are now offering formal apology and disclosure programs, and there are groups that now offer counseling and support to patients who have been harmed by a medical error. Above all, patients expect to be treated with respect and dignity at all times (and should be).

Dr. Morse relates the sobering statistic that while medical students are taught empathy early on in medical school, studies demonstrate that empathy declines during school and reaches a nadir during the third year and declines further during residency. Physician burnout, which is on the rise at an alarming rate, poses a significant risk to empathy, as burnout leads to provider indifference. Hopefully, initiatives that focus on physician wellness will help to improve empathy and, hence, patient care.

In our final article, Meegan Remillard gives an account of how she learned the art of communication in medical school and highlights the importance of this interaction with the patient. Already, she is lamenting the fact that she will not have time to spend with patients when she is a resident.

This is a very full issue, but please take time to read our regular feature articles. The Legal Consult describes the future of community hospitals in Massachusetts and presents some very staggering statistics. We have three very interesting As I See It pieces; two from medical students and a joint article from our president and executive director. In the movie review, Dr. Hirsh encourages everyone to see *Concussion*, an expose of the NFL's disregard of the welfare of its players. Please take time to read the President's Message by Dr. Fred Baker and the In Memoriam for Arthur Pappas, written by Eric W. Dickson, MD, and Michael F. Collins, MD. Also, don't forget to read Society Snippets!!

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President's Message

Frederic Baker, MD



Frederic Baker, MD

This message was delivered at the WDMS Annual Business Meeting on April 13, 2016.

As your district medical society president, I am happy to report that the Worcester District Medical Society continues to flourish. Founded in 1794, the WDMS is the third-oldest medical society in the country and the third-largest medical society in the state, with well over 2,200 members. Our society is strong, thanks to the remarkable and diverse talents and efforts of students, residents, physicians, the Alliance and the support of our community.

Our mission of advancing medical knowledge, promoting the highest professional and ethical standards and fostering an environment that is most conducive to enhancing the health of Central Massachusetts residents is evident every day, thanks to you.

As individuals and communities confront ever-increasing changes and challenges, the vision and mission of WDMS are as profound and relevant today as they were upon our founding more than two centuries ago. To paraphrase the columnist David Brooks, no person is born into a blank social slate, we are part of a society; the unwritten rules of our profession and the standards of excellence with which we identify guide us to leave an even better institution than the one we found. We make commitments to do something that transcends a single lifetime, and we take on the responsibility of preserving and improving this institution for future generations.

With so many demands and distractions that compete for our attention and time, membership in an organization must always carry a value for members and those whom they serve. I'd like to highlight some of the great accomplishments of this district medical society that reinforce why organized medicine is so critical.

Providing medical education programs for a diverse membership that are unique and timely is one of our priorities. On Oct. 6, the Louis A. Cottle Lecture featured an extremely well-received presentation by

Dr. Heather Forkey titled "Child Abuse and Trauma: Recognition and Response."

In our commitment to inspire and support future generations, thanks to your generosity, the Scholarship Fund was able to distribute a total of \$37,000 in scholarships to 12 medical students.

In March, the Women in Medicine Leadership Forum presented a wonderful presentation, titled "Generations at Work," that was open to all members.

WDMS is committed to raising awareness on important health care issues facing Central Massachusetts and to serve as a credible authority and welcome resource on health care advocacy. We are the only district society to feature a bi-monthly magazine, *Worcester Medicine*, and a weekly television show, *Health Matters*, featuring topical discussions with health care issues facing communities and Central Massachusetts. As part of our commitment to support our communities in efforts of public health, WDMS is on the forefront of addressing sensitive issues, such as helping people overcome addiction, successful establishment of a needle exchange program, promoting vaccinations and a civil discourse on gun safety.

The adage that there is strength in numbers is particularly true when it comes to advocacy. Members of the society passionately advocate for patients to ensure good outcomes. Organized medicine provides the venue for stronger advocacy that conveys to an even broader audience.

In concert with advocacy, the legislative committee hosted the annual Legislative Breakfast with Central Massachusetts legislators to facilitate the passage of pertinent legislation to ensure a healthy society. Collaborating with health care stakeholders to advance our mission of serving patients is a core priority.

It is always inspiring to recognize our colleagues for outstanding service, but even more gratifying when our community acknowledges them. In particular, we will always cherish the warmth and spirit that was present at the dedication of the Leonard Morse Stroll in Elm Park by the city of Worcester; admire the success of Café Reyes in its mission of transforming lives; and applaud the Worcester Department of Public Health's distinction as the first accredited state DPH, to name a few.

Preserving our history and learning from the past are realities made that much more accessible, thanks to the successful digitalizing of

the original records of the Union Medical Association (UMA) and the establishment of The Spoken History Project, which successfully archives video and audio interviews of senior physicians, thanks, in large part, to the efforts of curator Dr. Dale Magee.

Perhaps one of the biggest benefits of membership in organized medicine is not only in amplifying advocacy for your patients but in advocating for you. Many of you have probably seen the reports regarding physician burnout, with some estimates placing it at 50 percent nationwide. It is a growing concern that is associated with poor outcomes, early retirement, higher costs, less access and, ultimately, undermines efforts to train and retain a much-needed, highly skilled and motivated workforce. Certainly we appreciate and welcome efforts at reducing burnout on a personal level. However, that's not enough. It's reducing those elements that contribute to the burnout on a system level where organized medicine can and must intervene on your part and with your engagement. It is often noted that the greatest satisfaction that physicians derive is in the interactions and relationships with patients. Likewise, the greatest grievances raised are when physicians and caretakers encounter or perceive barriers to care and disruption of the patient-physician relationship.

I asked a patient of mine who is 102 years old of all the advances in medicine she has witnessed and experienced, which ones stand out the most. She spoke glowingly of the advances with antibiotics (recalling a time when there was no penicillin) and the technology that allows prescriptions to get transmitted to the pharmacy at the touch of a button. But the element that she cherished the most was the comfort she had in knowing that if she had a concern, she could call on her physician. The intimacy and power of the therapeutic patient-physician relationship is perhaps the one constant through medicine that defines the joy for all of us, and it transcends generations. It's a relationship of trust, respect and empathy, where the patient is always the center of attention, and ultimately affords the best outcomes. That is why no entity or policy should ever disrupt or undermine the therapeutic patient-physician relationship. If anything, our policies and systems must foster not only the success of such relationships, but more of them.

In closing, a special thank you goes to Joyce Cariglia, our executive director, and Melissa Boucher, our administrative assistant. Their tireless efforts, energy and enthusiasm make it possible for the WDMS to offer so much to members. Thank you to my wife, Kathy, and my kids for all their support and patience. I want to thank all of you for your support, engagement and for all the great things you do in serving the society and this community. Please stay engaged. It has truly been a joy and a privilege to serve in this capacity as your Worcester District Medical Society president. I look forward to the great work of our new president, Dr. James Broadhurst. Together we are truly stronger. Your ideas, friendship and energy are what define the society. Thank you so much.



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The Physician and Patient Relationship: The Effect of Technology

Eric Alper, MD, FACP, SFHM, CPE



Eric Alper, MD, FACP, SFHM, CPE

A recent study in *JAMA Internal Medicine*, reported on in the *Wall Street Journal*, suggests that patients that are less happy when their provider spends a lot of time looking at the computer. Another study, from Northwestern, reported that the physicians studied spend about 30 percent of their time looking at the computer screen during a visit. Despite potential risks of using computers as a part of patient care, these technologies also have the ability to substantially improve the way that we communicate with and care for patients.

Over the past 10 years, as the Meaningful Use program has resulted in the more widespread adoption of Electronic Health Records (EHRs) in our health care settings, the impact of these devices in and out of the exam room has been palpable. The move to computerizing the medical record has started to yield the value of making much more information about the patient available to the provider in real time. The ability to exchange information between EHRs is also becoming more prevalent and powerful. Epic systems in particular make it very easy to exchange information between anyone running Epic. The more broad adoption of Epic within Worcester and in New England will make it much easier to view information in real time about patients who have been cared for outside of one's own health care system.

EHRs also have the potential to improve communication in other ways. Patients now have unprecedented ease of access to their own records. Patient portals have proliferated as a direct result of the Meaningful Use regulation. Through these web-based systems, patients have the ability to view their laboratory data and other results in near real time. A recent movement in medical informatics referred to as "OpenNotes" is also encouraging the real-time sharing of all provider notes with the patient through the portal. Patients are also able to share information gathered on medical devices in their homes (glucometers, sphygmomanometers) directly into their portals, allowing their provider teams more real-time management of problems. Portals also facilitate electronic communications between the patient and the provider team. These new tools should allow for previously impossible levels of patient engagement with their own care and much higher levels of patient-provider communication.

Yet another recent development has been the growth of secure text messaging systems. For far too many years, physicians have relied upon the pager as their primary method for establishing communication with their office staff and other members of the health care team. Paging usually requires a call back, allows only limited numbers of characters, is only one-way communication, and sends messages that are not secure to meet HIPAA standards. Despite the fact that almost all physicians now carry smartphones, the fact that standard text messaging is not secure, and perhaps other factors, have limited our use of these devices for patient care communication. Most of us continue to carry the antiquated pager, as well. As we add the ability for providers to send secure text messages, one can easily send text messages to single providers or groups of providers simultaneously. One can capture photos on our smartphones to securely message (yet not save those images to our phones). The dialog allows the participants to immediately respond or to easily return the call to that physician's mobile phone. One can automatically indicate who is covering when not on service. Some of these systems even allow the provider to send secure text messages to patients' phones, as some patients prefer this mechanism of communication.

A number of authors have also discussed ways to reduce the impact of using the computer in exam room. Some have encouraged that it be thought of as a "third person" in the encounter. The computer should be placed so that the patient, provider and computer form a triangle, and the physician should not turn his/her back to the patient. The physician should use the computer to share information with and educate the patient. When used well, the presence of a computer in the exam room can enhance the patient encounter.

A number of these new tools have the potential to revolutionize the way that we communicate and, hence, the way that we deliver patient care and do our work. All tools have benefits and risks. A hammer, saw and drill can be used to build a house, but if used carelessly, can result in injury. These new tools that are made available by technology must be used appropriately to keep patient information secure, improve workflows, appropriately expose information to patients and preserve/improve the quality of the patient-physician relationship. When implemented well, these tools will help to realize the value of adding these new systems into patient care by delivering improved knowledge, collaboration, engagement, efficiency and effectiveness.

Eric Alper, MD, FACP, SFHM, CPE, is vice president and chief clinical informatics officer at UMass Memorial Health Care and is professor of Medicine at UMass Medical School.

Communication Skills Teaching at UMass Medical School: A Tradition of Excellence and Innovation

Michele Pugnaire, MD



Michele Pugnaire, MD

Since its first entering class was admitted in 1970, UMass Medical School has been recognized as a national leader in communication skills teaching and continues to be at the forefront of innovation in health communications education. The UMMS tradition of excellence and valuing of communication skills is deeply rooted and firmly established in the school's founding mission to advance excellence in primary care education and optimally prepare UMMS students to excel as tomorrow's physicians – caring, competent and fulfilled in their chosen career.

Responding to this charge, UMass was ahead of its time in establishing a required course in communication skills as part of its inaugural core curriculum, well before communication skills were officially pronounced as core competencies by the Accreditation Council for Graduate Medical Education and the Accreditation Council for Continuing Medical Education, following the turn of the new millennium in 2000. From 1991-2007, communication skills teaching at UMMS flourished under the leadership of Dean Aaron Lazare, nationally recognized communications skills expert and co-author of the landmark textbook *The Medical Interview: Clinical Care, Education and Research*, published in 1995. Fueled by national trends that included the required communication competency in GME and CME, the scope of communication skills teaching at UMMS has continued to diversify and expand beyond the foundational elements of the medical interview to include the broader dimensions of learning integral to health care communication, such as the doctor-patient relationship, professionalism, ethical reasoning, compassionate and caring attitudes, self-awareness and personal reflection.

Building on this strong foundation, UMass continues a trajectory of innovation and change in communication education by embracing new, state-of-the-art educational technologies and novel approaches to learning, which have promoted the quality and effectiveness of our communications skills curriculum and ensured that UMass Medical School graduates are best equipped with the communication skills competencies for their lifelong careers as physicians.

Perhaps the most widely recognized innovation in communication education at UMMS is use of standardized patients (SPs) for both teaching and assessing students' communication skills. A leading "early adopter" of SPs in medical education, UMass has developed a nationally recognized program for SP training. For more than three decades, the UMMS SP program has been formally training individuals to authentically and reliably portray "real" patients and accurately rate student communication skills in mock encounters that replicate real-world patient care. UMass makes extensive use of SPs across all years of the curriculum, in which OSCEs (Objective Structured Clinical Examinations) are in place for training our

medical students and nursing students. OSCEs create a series of SP-based case scenarios designed to address specific communication goals, ranging from the basic medical interview encounter, such as a patient presenting with chest pain, to more complex issues, such as breaking bad news, taking a sexual history and discussing end-of-life care and advance directives. While OSCEs are widely used to teach and assess communication skills in all core clerkships at UMMS, the curriculum has also pioneered the use of SPs in innovative educational programs that address important and emerging issues in health communication, including cross-cultural communication, domestic violence screening, professionalism, care of the geriatric patient, smoking cessation, substance abuse screening and counseling, motivational interviewing, interprofessional team-based care, and disclosure and apology for medical errors. Many of these UMMS educational programs have garnered competitive grants awards and regional and national recognition through publication in the high-impact journals in medical education and peer-reviewed presentations at national and international meetings of leading organizations in the field of education and communication.

Newest on the list of communications skills innovations at UMMS is the launching of the "multiple mini-interview" (MMI) program as part of the admissions process for the school of medicine. Now in its third year of implementation, the MMI has replaced the standard one-on-one medical school interview with a series of brief (e.g., eight-minute) encounters, in which the applicant interacts with an MMI "rater," who assesses the candidate's communication and interpersonal skills, as well as other foundational skills central to the practice of medicine, including critical thinking, ethical decision-making, self-awareness and professionalism. In each MMI encounter, the applicant discusses with the interviewer a scenario of general relevance to health care (e.g., drug advertising), with all interviewers rating the applicant using a common, standardized scale. The MMI has been extensively researched and, in a study at one medical school, was demonstrated to be the best admissions predictor of OSCE performance, as well as student's overall clerkship performance ratings (H. Reiter, *MedEd* 2007). The MMI has been positively reviewed by UMMS medical school applicants and is being used nationwide by roughly 20 percent of the 145 accredited U.S. allopathic medical schools. As national trends show more schools adopting the MMI model, UMMS has the distinction of being among the first cohort of medical schools nationwide to implement the MMI as a tool for identifying students with the communications skills and related abilities that will best prepare them as skilled and effective communicators in medicine and beyond.

Building on the MMI, the foundational skills of the medical interview, the use of SPs and OSCEs across all four years of the curriculum and state-of-the-art innovation in communication education, UMMS has stayed true to its founding mission for excellence in teaching and the ongoing advancement of communication as a cornerstone of the UMMS educational experience. Ask any of our UMMS graduates about the skills that they acquired in medical school that are most valuable to their practices today, and you will not be surprised to hear that it's the communication skills that most endure and make the biggest difference for our students as physicians and, most importantly, for the patients they serve.

Michele Pugnaire, MD, is a professor of Family Medicine and Community Health and senior associate dean, Office of Educational Affairs, at UMass Medical School.

Communication, the ‘Real’ Root Cause

Kelly Chandley, BSN, CPHRM

In 2012, Massachusetts adopted its new Disclosure, Apology and Offer Law, M.G.L. c.231, §60L, which was intended to shift how physicians and hospitals deal with unanticipated outcomes and errors that involve patients. Among its provisions, this law includes a mechanism for harmed parties to communicate directly with licensed practitioners and hospitals and provide the facts and how they believe they were harmed prior to filing a claim or lawsuit. Once this occurs, practitioners and/or hospitals must respond within 150 days. Although an oversimplification, the law is meant to encourage open, honest and clear communication between practitioners and patients with a goal of shortening what has traditionally been a long painful process for both sides. The proponents of this law touted that this would help physicians curtail “defensive medicine” practices, decrease insurance premiums and decrease negative health impacts on physicians who experience claims or lawsuits.

Most physicians would argue that open and honest communication has always been part of their practice. On the other hand, after adverse events, patients and families often feel that they were not well informed on either the risks of care and treatment or of the unintended outcome of that treatment. Indeed, similar to other types of relationships gone bad, poor communication is often at the heart of the problem.

The law defines an “unanticipated outcome” as a medical treatment or procedure that differs from the intended result – whether or not it was an intentional act. Section 223 of the law says that statements made to patients and/or families “expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error, or a general sense of concern” about an unanticipated outcome are not admissible, should further legal proceeding occur. It further says that any statement would become admissible if, under oath, the health care provider makes a statement that is “contradictory or inconsistent” with the previous statement. While well-intended, this provision only underscores the root cause of many interactions, that is, miscommunication. How can physicians really reduce the risk of encountering a claim or lawsuit? Work on the root cause: communication skills.

“Listen with the intent to understand, not the intent to reply.” Steven Covey’s wise words apply in so many different situations. This can be applied both proactively and reactively. Listening carefully to what a patient is experiencing and how his/her problem *impacts him/her as an individual* is critical in individualizing both care and communication with patients. Although prescribing a commonly used medication or recommending a procedure done routinely may be rote to a practitioner, it is often new information for a patient, who deserves to understand it in the context of how it may impact his/her individual circumstance. One needs to really listen to have that understanding for each patient.

Likewise, after something adverse happens, each situation is unique with regard to a patient’s or family’s understanding. Unexpected deaths, for example, may occur as a result of erroneous decisions *or* may be only unexpected to the loved ones left behind. Listening carefully and expressing compassion and an honest explanation of what happened is critical. But listening to and trying to understand the position of those left behind is equally important. This understanding should guide the need for further communication, even if “the standard of care was met.” The hospital’s or physician’s comfort that the care was adequate does not alleviate questions lingering for a family that was in shock at the outcome. Unanswered questions are an often-cited reason for pursuing legal action.

Even errors without significant consequences are worthy of good communication. These may seem inconsequential, but if not dealt with in a respectful and thoughtful manner, can grow to include either legal action or license action. A physician submits electronic prescriptions to a pharmacy under the wrong patient’s name, for example. The patient fills the prescriptions, prompted by an automated call from the pharmacy. Having just come from a doctor’s appointment, the patient commences to take the medications without question. After a conversation with a friend and reaction to the “odd prescription,” the patient calls the physician to ask why they were given these medications which weren’t discussed. A quick response that they were meant for someone else is insufficient to allay the patient’s anger at having been the victim of a mistake. An apology, clear instructions to stop the medications and noting the occurrence and subsequent communication are critical. Especially in this world of social media and rapid communication, a patient can relay this experience to many people simultaneously, only to receive encouragement to complain to a licensing agency or health care licensing or accreditation agency, at the least. Listening carefully to the actual concerns and then going back after thoughtful consideration and investigation is often more satisfying, both for patients and for physicians. The patient’s perception of the physician or hospital’s concern for them after even a ‘harmless’ mistake plays a key role in their next steps.

“Everybody blames the culture without taking responsibility.” James Levine hit the nail on the head when he said this. Health care has gone through so many shifts in how it deals with errors and outcomes that one can barely keep up. Historically, errors and outcomes were hidden, until the widespread publication of the IHI’s 100,000 Lives Campaign changed investigating and dealing with errors, along with public reporting. The consequences went from “shame and blame” to “blameless” to “just culture.”

However, the perception of what is “just” differs, depending on where you are seated. Consequences for physicians have remained a significant factor in how they deal with such occurrences. Public access to license actions and complaint information, as well as their impact on credentialing at hospitals, remain real concerns for physicians. Accepting responsibility for one’s own actions can be challenging, but it is made more important in the context of the Apology and Disclosure Law’s language about conflicting statements. This makes it all the more important for practitioners to participate in investigations about adverse outcomes, clearly understand the real root causes, accept responsibility when necessary and accurately communicate with patients. Patients often perceive their physicians as leaders and expect to hear from them when an adverse outcome occurs, whether or not the individual physician played a role in causing the event. A coordinated, team approach to post-event communication is often successful in providing answers and closure for all, thus reducing the risk of further action. This requires good communication among all interested parties – physician, patient and other providers or hospital, if involved.

Whether or not one ever experiences such situations, committing to improving communication skills by intentional listening, taking responsibility and working together to improve care and coordination will all help attain the goals that moved Massachusetts to create this law.

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The Aftermath of Medical Errors – 2016

Randolph R. Peto, MD, MPH



Randolph R. Peto, MD, MPH

Few physicians gain extensive experience handling the immediate aftermath of significant patient harm caused by medical error. Yet, collectively, medical harm occurs at alarming rates. Physicians and their families are not immune from suffering harm to themselves from error.

In 1987, the Lexington, Ky., Veterans Administration hospital inaugurated processes to respond to medical errors with increasing honesty, transparency and compassion. In the following decades, large institutions, such as the University of Michigan and Stanford University, followed suit. However, adoption of this innovation is quite variable across the U.S., including in

Massachusetts, given the substantial shifts needed in institutional mental models and cultures.

Responding to error, physicians might best channel what one would desire for loved ones harmed by medical care, e.g., apply the Golden Rule. We, just like patients, want to learn expeditiously the facts about what caused the harm and what can be done to mitigate the impact. We don't expect to incur additional out-of-pocket expenses. We want someone to take responsibility, and if indicated, we want a sincere apology. Lastly, we want assurances, and sometimes proof, that the system is being improved to significantly reduce the chance of future patients being harmed in the same way.

A number of Massachusetts hospitals, large ambulatory group practices and medical liability insurers now have formal disclosure and apology programs (some prefer to use alternative terminology, e.g., "Communication, Apology, and Resolution"). Providing "just-in-time" coaching and support to the clinician on the "sharp end" of an error is a cornerstone of these programs. Such programs help the clinician anticipate the difficult emotions that patients and families often exhibit in the aftermath of medical harm and remind clinicians of compassionate methods to communicate going forward. Expeditious investigation of factors leading to the medical error demonstrates due concern to the patient and family. The legendary UCLA basketball coach John Wooden provided wonderful advice applicable to this situation, "Be quick, but don't hurry." A hurried speculation to the patient about potential causes may further fracture the patient relationship if one guesses wrong. In Massachusetts, the Medically Induced Trauma Support Services (mitss.org) provides counseling and emotional support to those who have been harmed, with the focus on patients. Peer support programs in some hospitals link volunteer physicians naturally skilled in listening to physicians who have made an error. Such volunteers serve primarily as sounding boards and empathic colleagues rather than formal counselors.

Resources are expanding for learning about optimum disclosure techniques. Aaron Lazare, MD, the late chancellor and dean of the UMass Medical School, published the highly recommended book, *On Apology*, in 2004. In 2012, The Massachusetts Alliance for Communication and Resolution following Medical Injury (macrmi.net) initiated the sharing of data and lessons learned among a number of hospitals, insurers and organizations

committed to complete transparency. The group's website provides a number of resources. The Open School program of the Institute for HealthCare Improvement (ihi.org) provides an online module, "Communicating with Patients after Adverse Events." This module is free for university faculty. Robert Truog, MD, of Boston Children's Hospital is the lead author of the text *Talking with Patients and Families about Medical Error*. Simulation centers, including the center at the UMass Medical School, increasingly train medical students and resident physicians in disclosure and apology techniques – through roleplaying, simulated patients and communication skills feedback utilizing videotaping.

Most of the disclosure innovations, by default, operate "downstream" from the medical error. Other upstream interventions are designed to error-proof (to the extent possible) the working environment in which mistakes happen. Just Culture approaches work to end the "shame and blame" milieu, which physicians may still encounter after an error, while, at the same time, maintaining professional accountability. Such cultures carefully study in-place systems, including "latent" threats which make it likely that other physicians, "but for the grace of God," will fall into similar error traps. Just Cultures strongly encourage, value and efficiently utilize the submission of mistakes and near-misses to "patient safety reporting" databases. Traditionally, physicians have contributed far fewer stories to these databases than nurses – an obvious opportunity for improvement.

In our attention to the very traumatic consequences and emotions following serious medical harm, we often overlook one important mitigating factor. Patients expect to be treated with decency and respect at all times. Physicians who have not established such a relationship with a patient and family prior to a medical error may find it challenging, if not impossible, to establish trust and respect after the error. Patients and families often forgive overwhelming harm (including death) when such respectful relationships have been established from the beginning of the therapeutic relationship. And in today's team-based environment, relationships between patients and other licensed professionals on the health care team can be just as important for establishing a platform of respect. I suspect the medical education system does not stress enough the long-term impact (e.g., to patient outcomes, to forgiveness of physicians after an error, etc.) of the quality of relationships with patients from the outset – and how to effectively accomplish such in our time-constrained patient encounters.

One of the most difficult challenges in the aftermath of a harmful, preventable event is to honor the altruistic desire, and often expectation, by patients for the organization to significantly reduce the chance of similar errors to future patients. Part of making meaning of preventable suffering can be the hope of reducing suffering by others. About two-thirds of serious adverse events involve communication failures. Yet, communication breakdowns don't often lead to quick or easy fixes in complex health care environments. Organizations that take these altruistic patient aspirations to heart need to marry timely harm event investigative findings with system improvements, such as ongoing teamwork communication training (e.g., TeamSTEPPS described at ahrq.gov).

Practicing physicians (and their staffs) are well-served to identify, and frequently update, contact numbers for just-in-time disclosure/apology coaching resources available in their practice settings and from their medical liability insurance carriers.

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Integration of Communication in an Accelerated Doctor of Pharmacy Curriculum

Jennifer L. Donovan, PharmD, and Michael J. Malloy, PharmD



Jennifer L. Donovan, PharmD, and Michael J. Malloy, PharmD

Communication is an essential skill that pharmacists must have in order to provide patient-centered care and to be effective members of the health care team. Pharmacists use communication skills to promote the safe and effective use of medication and to advocate for their patients and profession. For example, pharmacists educate patients and prescribers on the proper use of medication and recommend evidence-based therapies to prescribers, as well as get involved in developing policies and drug therapy protocols and algorithms. Additionally, pharmacists must document their care plans, provide consults for various clinical services and create drug monographs and educational materials for dissemination. Research indicates that effective communication is associated with improvement in patient care, patient satisfaction and in the patient's ability to self-manage chronic conditions.¹⁻⁴ The Accreditation Council for Pharmacy Education Standards, which is the national accrediting agency for pharmacy programs, specifies that a pharmacy graduate must possess effective and appropriate communication skills for multiple practice settings and to various constituents.⁵

The Center for Advancement of Pharmacy Education (CAPE) 2013 Educational Outcomes guide and support the standards with a scaffold of specific curricular outcomes and objectives.⁶ The communication outcome is defined by CAPE as, "Communicator – effectively communicate verbally and nonverbally when interacting with an individual, group, or organization." The corresponding objectives for this outcome are listed in Table 1, which serves as the "road map" on how to achieve the communication outcome. Communication must be interwoven horizontally and vertically within the curriculum, appropriately sequenced and increased in rigor in order for graduates to possess the prerequisite knowledge, skills and values expected. Here we describe the process of how the School of Pharmacy – Worcester/Manchester (SOP-W/M) integrates communication within the curriculum.

The SOP-W/M is an accelerated, multi-campus program with approximately 310 students (250 in Worcester and 60 in Manchester, N.H.). A Curriculum Map and Course Assessment Subcommittee was formed to systematically document and assess the curricular outcomes for the program and to ensure that the curriculum is properly sequenced and devoid of unnecessary redundancies and gaps. Qualtrics, an online survey tool, is used as the electronic mapping tool. At the beginning of each semester, faculty members complete the Qualtrics survey. They must select which curricular objective is delivered and assessed in their course and categorize the level of learning and performance for each curricular objective. The level of learning is a framework to assign a faculty member's expectation of student learning.⁷ There are three categories: ideas (student has basic knowledge); connections (student uses basic concepts to make connections or form relationships); and extensions (student synthesizes knowledge and uses concepts to extrapolate and make informed decisions). These categories indicate where students are along the learning continuum. The performance level is a framework to assign a faculty member's expectations of student performance for that curricular objective. The three categories for performance level are: novice (student has cognitive abilities limited to facts or does not connect knowledge to pharmacy practice); functional (student demonstrates ability to connect knowledge with pharmacy practice; requires minimal supervising or coaching); and competent (student demonstrates ability to independently and consistently synthesize and extend knowledge to pharmacy practice; student does not require supervision in pharmacy).

There are several didactic courses in each professional year of the program, as well as experiential (e.g., clinical rotation), which include content on communication, provide practice opportunities and incorporate assessments. The rigor and expectations evolve horizontally and vertically. Figure 1 illustrates the number of courses in each professional year (e.g., P1, P2, P3) based on level of performance for each communication curricular objectives.

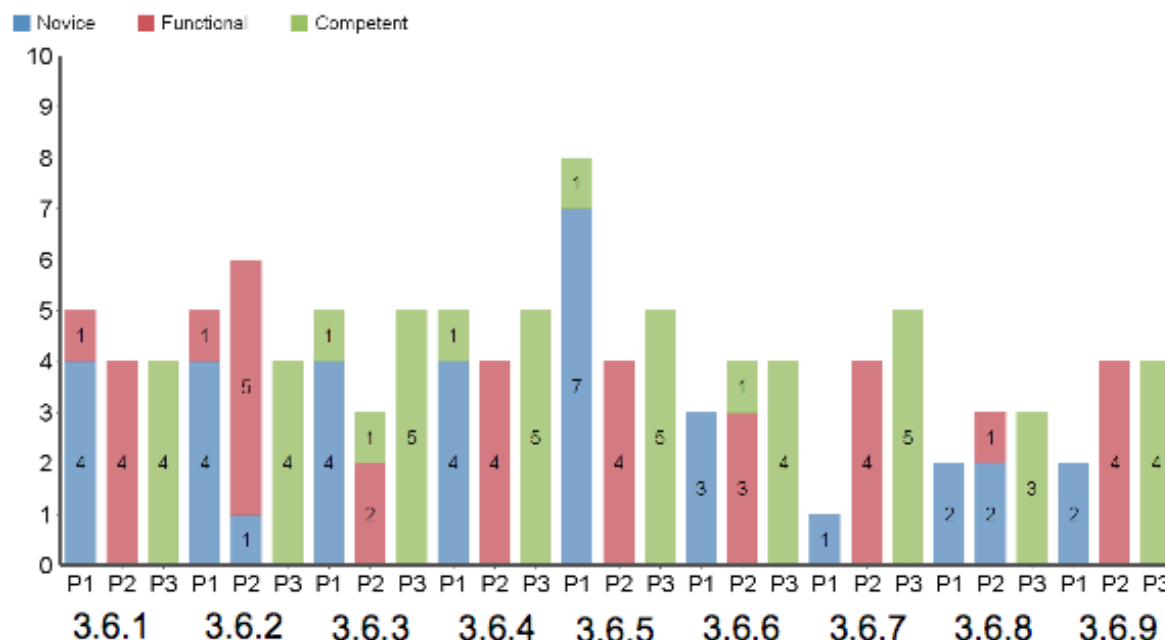
In summary, communication is an essential skill that pharmacists must possess to be an effective health care provider. Communication is an accreditation requirement that schools of pharmacy incorporate in their curriculum. At the SOP-W/M, communication is delivered and assessed in each professional year of the program, and performance expectation increases horizontally and vertically within the curriculum. This design allows students to progress through the continuum of learning and to possess the prerequisite skills that are expected from a pharmacy graduate.

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Table 1: Communication curricular objectives for the School of Pharmacy – Worcester/Manchester, which are adapted from the Center for the advancement of pharmacy education 2013 educational outcomes.⁶

Curricular Objective #	Curricular Objective Statement
3.6.1	Interview patients using an organized structure, specific questioning techniques (e.g., motivational interviewing), and medical terminology adapted for the audience.
3.6.2	Actively listen and ask appropriate open- and closed-ended questions to gather information.
3.6.3	Use available technology and other media to assist with communication as appropriate.
3.6.4	Use effective interpersonal skills to establish rapport and build trusting relationships.
3.6.5	Communicate assertively, persuasively, confidently, and clearly.
3.6.6	Demonstrate empathy when interacting with others.
3.6.7	Deliver and obtain feedback to assess learning and promote goal setting and goal attainment.
3.6.8	Develop professional documents pertinent to organizational needs (e.g., monographs, policy documents).
3.6.9	Document patient care activities clearly, concisely, and accurately using appropriate medical terminology.

Figure 1: The number of courses in each professional year (e.g., P1, P2, P3) based on level of performance (e.g., novice, functional, competent) for each communication curricular objective (e.g., 3.6.1-3.6.9).



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Empathy in Medical Practice

Randall J. Morse, MD



Randall J. Morse, MD

"I think we all have empathy. We may not have enough courage to display it." - Maya Angelou

In contrast to sympathy, when a person feels sorry or pity for another, Merriam-Webster defines empathy as "the feeling that you understand and share another person's experiences and emotions." Empathy gives us the ability to augment other aspects of the patient encounter and the patient-provider relationship.

Multiple benefits for both providers and patients have been linked to empathy, including, but not limited to, patient satisfaction and adherence,¹ improved clinical outcomes^{2,3} and decreased malpractice suits.⁴ Perceived empathy increases patient engagement and openness around symptoms and concerns and/or reasons for a visit that may not be

obvious at first glance. In turn, improved communication between provider and patient may lead to more precise diagnoses and effective treatment plans. Thus, in addition to providing high-quality care for patients, potential financial incentives exist with regard to reimbursements (by way of patient satisfaction scores), clinical outcomes (via performance on core measures) and decreased risk of potential litigation costs.

Given the impact of empathy on the medical interview and the patient-provider relationship, students are exposed to the concept during their first year of medical school. Furthermore, most medical schools have dedicated courses aimed at developing medical interviewing skills, ranging from obtaining a thorough medical history to social interaction skills, such as conveying empathy. Students develop these skills under the direction of faculty mentors, oftentimes during interviews of standardized patients (SPs). Additionally, students often receive formative feedback from SPs regarding their portrayal of verbal and non-verbal empathy from the unique perspective of the patient, which correlates with clinical examiner ratings of actual patient interactions.⁵ Verbal empathy may include acknowledging how difficult a particular situation may be. Non-verbal behaviors may include nodding in agreement, a comforting touch of the hand or shoulder or simply a moment without speaking to allow for reflection and processing. Unfortunately, a number of studies demonstrate that empathy declines during medical school, hitting a nadir during the third year,⁶ which declines further during residency training programs. However, studies support the use of self-reflection, written and in small groups, to combat decline of empathy, giving rise to the widespread use of reflective exercises.^{7,8}

As providers, can we truly understand what a patient is going through? Maybe. Our professional and personal experiences vary greatly, providing us with different levels of potential understanding of patient experiences, emotions and struggles. Additionally, although many providers may feel empathetic during a patient encounter, effectively communicating these feelings may present a challenge. How do we convey empathy? One potential resource is Vital Talk, which offers both online and hands-on courses exploring difficult conversations. The site also contains video blogs by Dr. Anthony Back, discussing potentially difficult patient scenarios along with skills to deal with these situations, such as acknowledging and naming an emotion.⁹ Although Vital Talk primarily focuses on conversations pertaining to serious illness and end of life, many of the tools provided can be generalized to other patient interactions and medical conditions of varying severity. Additional courses, such as the online "Empathetics" curricula utilized by Partners Healthcare or workshops dedicated to empathy and interviewing skills at the annual meetings of different medical societies, are also valuable resources.

Once in practice, how do we receive real-time formative feedback on

communication skills, such as empathy? Patient satisfaction scores lag behind encounters and are often generalized. Thus, assessing how specific conversations went from the patient perspective proves difficult. Certainly, receiving a card, phone call or unexpected thank-you visit from a patient or family member can reinforce positive behaviors. What about interactions that did not go well? In their simulation centers, some institutions offer additional training for providers on interviewing skills, including empathy, with expert feedback and video self-review, similar to techniques that have proven beneficial with medical students. The key to improving many skills, empathy portrayal included, is practice and real-time constructive feedback.

Physician burnout poses a significant risk to empathy, as burnout often leads to provider indifference. One recent study conducted by the American Medical Association (AMA) and the Mayo Clinic demonstrated the rate among physicians with at least one symptom of burnout increased from 45 percent to 54.4 percent from 2011 to 2014, with physicians practicing in Emergency Medicine having the highest rate of burnout, greater than 70 percent.¹⁰ Furthermore, the same study found that satisfaction with work-life balance declined from 48.5 percent to 40.9 percent over the same period. For physicians who have developed skills in the conveyance of empathy, risk for physician burnout has actually been shown to decrease. Many of us who have felt burned out in the past likely agree that empathy suffers during these times. Given the impact of physician burnout, this past year, the AMA set forth an initiative, AMA STEPS Forward, outlining strategies to identify and combat physician burnout and provide practitioners with additional resources.¹¹

Can we teach empathy? Maybe. The better question may be "Can we teach providers strategies to convey empathy better (or to appear empathetic)?" Absolutely. Can personal experiences increase providers' empathy? I think so. We all have experienced patient relationships, which, for some reason, touch us deeper than others. Maybe it was a patient with aggressive small cell lung cancer picked up on a chest x-ray obtained for a nagging cough or a patient passing from sequelae of a cord stem cell transplant for myelodysplastic syndrome. Building on experiences and relationships may provide us with the ability to better empathize with future patients going through difficult situations. I'm hopeful that further extension of initiatives focusing on physician wellness and combatting provider burnout, such as the use of self-reflection, and improvement in communication skills can help advance the abilities of providers to convey empathy and improve patient care in the long run.

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Listen Up: The Patient Interview From Student to Physician

Meegan Remillard, MPH



Meegan Remillard, MPH

“Tell me what brings you in today,” a simple, yet utilitarian, statement with which to open an interview that communicates that we are interested in the patient’s story and are here to listen. This opening is one of the first skills we learn as brand-new medical students in Doctoring & Clinical Skills, the course in which we learn the patient interview and physical exam. What comes next is where the art of medicine takes its turn, as we dance between strategic open-ended questions and more targeted questions that help us to focus in on our patient’s chief concern. As first-year medical students, we run down a list of memorized and rehearsed questions;

we are barely able to listen to our standardized patients as we struggle to collect all the required elements of their history.

By the time we begin our third year and enter the clinical component of medical school, the questions begin to come more naturally, which is essential, as we are now expected to interview real patients. It is between the third and fourth years that we must begin to decipher what is and is not important. Too many times did I learn about the health issues of my patient’s great-grandmother, how many pets his sister has and if he remembers to wear sunscreen in the summer, only to forget to ask how long has he had abdominal pain. To say we can easily get lost in the minutiae of the complete history is an understatement. If we use too many open-ended questions, we may end up hearing all about our patient’s vacation to Maine, whereas if we use too many close-ended questions, we may miss the fact that we should consider Lyme disease as part of our differential diagnosis. As we mature as clinicians and history-takers, we begin to take a concise, but complete, history. Only a few months away from graduation, I have refined my history-taking from a 45-minute interview to 10-15 minutes in the inpatient setting, and more importantly, I am refining how to present the relevant aspects to my residents and attending physicians.

This process of mastering the patient interview is an essential component of our medical education. As much as we need to understand the pathophysiology, pharmacology and anatomy, we must all know how to elicit a story and relay that story to other health care professionals. To put this in perspective, my husband recently graduated from veterinary school, and history-taking and communication skills comprised all of eight hours of formal class time. Compare this to two hours of Doctoring & Clinical Skills weekly for the first two years of medical school, many

curriculum days woven into the third and fourth years, with a heavy focus on communication, and at least a dozen testing situations with standardized patients. There are obvious differences between the veterinary and medical curriculum requirements, and this underscores just how important communication is in human medicine.

As a fourth-year medical student, I feel I am at a crossroads with how I will continue to evolve as a physician. I enjoy talking with patients and learning a few – to be honest, often more than a few – non-medical tidbits about their lives. However, I currently enjoy a luxury that will most certainly disappear once I hit the wards in June: time. Dr. Suzanne Koven describes this loss of time in her perspective piece, “The Doctor’s New Dilemma,” recently published in the *New England Journal of Medicine*¹.

After all these years of learning the art of communication, once in practice, it appears this may have all been in vain. We, as physicians and future physicians, are facing a health care environment that does not support talking to our patients. We cannot bill for asking “non-medical,” but often very relevant, questions and are often faced with short appointment times, double bookings, endless documentation requirements and the perpetual feeling and reality of always being behind. Dr. Koven cites several patient encounters where a connection augmented medical care; however, she concludes her piece with a less-than-optimistic outlook. After closing a patient encounter with ordering bloodwork and a prescription for anti-diarrheal medication, rather than delving deeper into her patient’s presentation and understanding what is truly worrying her, Dr. Koven feels a sense of what she identifies as despair. She cannot probe further into the patient’s history, not because she is not interested or concerned, but because she simply does not have the time.

I know that as an internal medicine resident, time will be an elusive commodity. My hope is that my training has prepared me to maximize the time I do have and to communicate efficiently, compassionately and effectively. When I ask my patients, “Tell me what brings you in today?” I will allow them to answer, and most importantly, I will listen because that is what I have been taught. Though I fear the dilemma Dr. Koven has presented and I am sure I will find myself in many similar scenarios, I am also sure that, like Dr. Koven, there will be other situations when I can build rapport with my patients, if only for a moment, through the masterful art of communication.

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The Future of Community Hospitals in Massachusetts

Peter J. Martin, Esq.



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Massachusetts health care providers are well aware of the long-term trend of consolidation in the industry – recent examples being Lahey Clinic’s pursuit of Elliot Health System in Manchester, N.H., and the proposed merger of two Baystate Health Care facilities – Mary Lane Hospital in Ware into Wing Hospital in Palmer. They are also acutely aware of the price differences between community hospitals and academic medical centers, as described in recent reports issued by the Attorney General’s office. A recent report from the Health Policy Commission provides detailed and disturbing information about this trend. The report also suggests that significant regulatory action

may have to be taken to try to ameliorate the price-distorting effects of this consolidation trend. The HPC’s analysis and suggestions about preserving high-value community-based care options are intriguing and suggest opportunities for collaboration between community hospitals and other provider organizations.

The recent HPC report, “Community Hospitals at a Crossroads,” assembles a large number of findings from studies conducted by the HPC and others that collectively paints a dire picture for unaffiliated community hospitals.

For example:

- The five largest hospital systems accounted for 54 percent of commercial payor discharges in 2012 and 61 percent of such discharges in 2014
- 75 percent of all primary care provider visits went to PCPs affiliated with the top eight provider systems, representing 79 percent of all PCP visit revenues in Massachusetts
- Although the cost of a low-risk delivery at a community hospital is 17 percent lower than the same delivery at an academic medical center, six hospitals – five of them with above-average costs – had 53 percent of such deliveries (Partners Healthcare accounted for more than 35 percent of low-risk deliveries)
- Fewer than half of patient discharges at Boston’s academic medical centers required AMC-level capabilities

The HPC report also makes the following observations. Most low-acuity services provided by community hospitals are not profitable. Community hospital costs per inpatient stay are, on average, \$1,500 less than inpatient stays at AMCs. Having more public-payor patients correlates with lower commercial payor reimbursement rates. If current hospital utilization trends continue, the average community hospital occupancy rate would be 50 percent in 10 years.

Relying on informed consumers to identify and insist on care at lower-cost community hospitals is not likely to be effective, according to consumer surveys and focus groups described in the HPC report. Survey and focus group participants reported almost no reference to quantitative measures of quality; instead, patients rely on the recommendations of family, friends and

physicians. Patients associate lower-cost facilities with “low-budget” care and have greater confidence in physicians who graduated from prestigious medical schools. Patients also have the perception that, having invested significantly in health insurance premiums, they want to “get their money’s worth” for that coverage by obtaining care at higher-cost hospitals.

Relying more generally on the market is also not likely to be effective, according to the HPC. Market forces have resulted in the consolidation of hospitals and physician groups into large systems anchored by academic medical centers, and these large systems are able to direct patient referrals to higher-cost facilities. One measure of that ability to steer patients is that every region in Massachusetts experienced a net outflow of patients for inpatient care, except metropolitan Boston. Hospitals with greater market leverage can command higher prices from payors, can use those higher prices to invest in new satellite facilities and the acquisition of physician practices, and can thereby enjoy more patient referrals, at the expense of hospitals with lesser market power. The HPC observes “higher prices that are not tied to quality, complexity, or other common measures of value create costs to consumers, businesses, and the state budget, and threaten the sustainability of lower-priced providers, including many community hospitals.”

What is to be done? The HPC report does not specify any particular solutions, but proposes assembling key stakeholders to address three broad themes. First, support the transformation of community hospitals into community-based systems of care. Second, encourage consumers to use high-value providers. Third, create a sustainable, value-based payment system. This is a familiar refrain – providers, patients and payors must all do something to create an efficient, accessible and high-quality health care system. While the suggested payor measures, such as providing financial incentives to patients to choose lower-cost providers, adopting higher-cost differentials between preferred and non-preferred provider tiers and improving risk adjustment models to account for factors that impact community hospital patient populations may have some marginal effect over time, it appears unlikely these steps would significantly or quickly alter the landscape in favor of community hospitals.

Instead, the HPC report strongly suggests that community hospitals need to collaborate with other types of outpatient providers in order to “transform” themselves into systems that align provider types and capacities to identified local health needs. The report mentions limited service clinics, urgent care centers and ambulatory surgery centers as possible partners. The HPC report notes that two-thirds of Massachusetts residents live within five miles of an urgent care center, and three out of five residents live within five miles of a retail clinic. Community health centers and other components of accountable care organizations, as well as social service organizations and behavioral health providers, may also collaborate usefully with community hospitals in an effort to retain patients within the hospital’s service area and stem the outflow toward Boston.

If regulatory and reimbursement barriers to this sort of community-based collaboration can be removed or their effects mitigated, community hospitals may have a good chance of reversing the current damaging trends. These hospitals’ increasing interest in such partnerships may create opportunities for providers of all types to engage in creative realignments and new structures. Practitioners should keep abreast of these developments to determine how they might fit into these new arrangements.

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

A UMass Student Perspective on Fostering Compassionate Care in our Community

James Doolin, BA



James Doolin, BA

Each year, 500 students at the University of Massachusetts Medical School are learning to become compassionate doctors. Our curriculum includes lessons on effective communication and patient-centered care, but these humanistic values can become lost during busy third- and fourth-year clinical rotations. In order to inspire compassionate care, students in the UMass Gold Humanism Honor Society (GHHS) led local participation in the national Tell Me More program as a part of

GHHS Solidarity Week for Compassionate Patient Care.¹

The Tell Me More program focuses on personalizing the patient interview by asking providers to add three humanistic questions to daily pre-rounds. Answers are shared with the medical team on a small poster displayed in the patient's room.

The Tell Me More Program was successfully piloted at UMass University campus last year by GHHS students.² This year, we grew the program to more than 40 student participants who interviewed patients at University, Memorial and Saint Vincent hospitals. We displayed de-identified patient quotes in the University campus cafeteria, reminding our community of the event. We added to the week's events by highlighting UMass medical student longitudinal "Capstone" projects that promote humanistic endeavors.

From our experiences participating in the Tell Me More program, we felt that establishing connections with patients was the most powerful lesson learned. Hazel Briner, MS3, commented, "I think it provided some much-needed insight for both provider and patient as to how to best motivate self-healing and provide hope." Casey Hamilton, MS3, was able to have many conversations with his patient about kayaking, fishing and construction based upon the patient's poster. The student felt these conversations "helped [the patient] to focus on things outside of his hospital room and his illness,

and it definitely helped me in realizing and appreciating the patient beyond his illness and treatment."

This year's event succeeded thanks to broad-based support from Worcester's major teaching hospitals (University, Memorial and St. Vincent hospitals). President and CEO of UMass Memorial Health Care Erick Dickson, MD, said, "As physicians, we work with our patients to get to the root of what is affecting their health as quickly as possible, and sometimes the subtleties of engaging them in a conversation beyond their current situation gets lost. Solidarity Week for Compassionate Care is a good opportunity to refocus on this important aspect of the doctor-patient relationship." We received similarly positive feedback from UMMHC CMO Margaret Hudlin, MD, and physician-educators, including Becky Spanagel, MD, who we would like to recognize for her support.

This year's Tell Me More program succeeded in promoting compassionate care in medicine teams and positively impacting patients during their hospital stays. We look forward to sharing what we've learned with next year's GHHS student inductees, so this annual event can continue to grow in ways that benefit patients and bring compassion to our community.

In addition to the students and patients who participated, we would like to thank the GHHS national office for facilitating this event; our local GHHS advisors, Suzana Makowski, MD, and Mike Ennis, MD; the Patient Experience Office at University of Massachusetts Memorial Medical Center; and the many clinician-educators who supported Solidarity Week.

Jim Doolin, BA, is a fourth-year medical student at UMass Medical School. He writes on behalf of the Solidarity Week Subcommittee of the Gold Humanism Honor Society UMass Med Chapter, including Rachel Erdil, Jennine Weller, Julia Randall, Emily Levoy, Kathryn DeCarli and Kathryn Bailey.

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Worcester Department of Public Health Receives National Accreditation from the Public Health Accreditation

Frederic Baker, MD, and Joyce Cariglia

The Worcester District Medical Society, like so many organizations involved in health care delivery and improved access to health care, received with great joy the news that the Worcester Department of Public Health received its National Accreditation from the Public Health Accreditation Board on March 17, 2016. The long-standing relationship between the Worcester District Medical Society and the Worcester Department of Public Health is one of our proudest relationships. The Worcester District Medical Society, which represents more than 2,100 physicians in Central Massachusetts, has a very active membership that includes a Public Health Committee. For at least the past 15 years, the Public Health Committee has benefited from representation from the Worcester Department of Public Health. We have helped to promote various aspects of the department's agenda, including Community Immunity, drug take-back days and the Greater Worcester Gun Buyback. Three of our WDMS presidents have served as commissioners or medical directors of the DPH, including the iconic Dr. Leonard Morse, Dr. Dale Magee, and most recently, Dr. Michael Hirsh.

What does accreditation mean for Worcester and the 400,000 residents in the Central Massachusetts Regional Public Health Alliance (CMRPHA)? Accreditation gives recognition to a very small division within the Department of Health and Human Services that the work it is doing has been benchmarked and reaches incredibly high national standards. There are more than 5,000 Departments of Public Health in the country. Only 117 have been granted this accreditation. No other department in the entire Commonwealth of Massachusetts has met the criteria for accreditation as of yet.

Incredibly, the WDPH has done this after rising out of the ashes of a devastating budget crisis in 2008, which led the department to be cut from more than 100 full-time employees down to just four. When City Manager Michael O'Brien, in 2009, commissioned a task force to see how the Department of Public Health could be reconstituted,

a major component of that roadmap forward was obtaining federal accreditation.

First, many things had to be put in place. A Community Health Assessment Plan (CHA) had to be performed. Many of our WDMS members participated in that Community Health Assessment. The Community Health Improvement Plan (CHIP) was crafted and launched in 2013. An Academic Health Department, which would give the Department of Public Health access to students of various institutions of higher learning within the Central Massachusetts area to help advance CHIP-related programs, also had to be established. A regionalization process that led the WDPH to expand from the city proper to six surrounding municipalities (Holden, Shrewsbury, Grafton, Millbury, Leicester and West Boylston) also was part of this reconstitution phase. In the end, the WDPH has shown that with collaboration, with regionalization and with an academic approach to public health, one could advance our dream of becoming the healthiest health district in New England by 2020.

Of course, this aligns perfectly with the goals of the Worcester District Medical Society. Our physicians are tireless advocates for the improved access to care and the improved public health awareness of our patients. We applaud the City of Worcester, the Central Massachusetts Regional Public Health Alliance Municipalities and the Worcester Department of Public Health for this much-deserved recognition. The accreditation will undoubtedly afford the WDPH grant opportunities and new collaborations that will take it to even greater heights. We see only great things coming from this division moving forward, and we look forward to our continued partnership.

Congratulations to all!

Frederic Baker, MD, is the president of the Worcester District Medical Society.

Joyce Cariglia is the executive director of the Worcester District Medical Society.

Scribonius Largus

Felipe Fernandez del Castillo

We don't know much Scribonius Largus about Scribonius Largus. The first-century Roman physician has been overshadowed by more famous medical authors like Celsus, Pliny and Galen. Dismissed by one scholar as "second rate,"¹ Scribonius has lurked for centuries in the footnotes of history textbooks and journal articles, and the bulk of his only work is, as yet, untranslated into English.

It is easy to see why. The *Compositiones Medicamentorum* is a distinctly "low yield" book. Written in tortured Latin, the book contains about 300 medication recipes: lists of ingredients and instructions for turning them into remedies. Few anecdotes relieve the monotony, and though some of Scribonius' remedies are intriguing, and fewer are plausible, most are either useless or harmful.

Yet Scribonius is a unique voice among ancient medical authors. Far less polished than any of his contemporaries ("if the Latin of Celsus is...a glass of sparkling wine, that of Scribonius is not far from dishwater."¹) there is a refreshingly folksy, down-to-earth quality to his writing. Though his work teems with references to the titans of ancient medicine, he is also happy to cite "a certain good woman who lives in Rome," and he applauds the efforts of folk healers who are "eager to assist the sick in any way possible."

Furthermore, Scribonius is a model physician in his dedication to his patients. We see this particularly in his Preface, where he argues that physicians should be motivated by kindness (*humanitas*) rather than materialistic aims.^{2,3} We also see it in the number of references to other books and other physicians in his text. Though sometimes Scribonius' reliance on the limited scientific tradition of his time leads him spectacularly astray (see, for example, his recommendations on tourniquets below), it is clear that he regards his profession as a privilege and feels compelled to muster all the resources he can to the service of his patients. On these grounds alone, modern clinicians will feel a kinship with their 2,000-year-old colleague.

I present below a selection of original translations from Scribonius' work.

Preface: On The Use Of Medications

The late Herophilus, accounted among the greatest physicians, is said to have stated: "Medications are the gift of the gods." I think he was right, for medications, tested by use and experience, excel what miracles are able to accomplish. Often among the disputations and debates of the most renowned and authoritative physicians, where I have sought for what to do and how to help the sick, I have found humble and otherwise unknown folk who have become most skillful by practical experience. I blush to say it, but

far removed from the profession ... they have freed the sick from pain and danger by administering an effective drug, just as though a divine power were present. For this reason, those who attempt to defile what is called "medicine" through the use of medications not for the sake of healing, but for the sake of [flaunting] the power and efficacy of medications, should be condemned. However, those who are eager to aid the sick in any way they can should be applauded.

Preface: On The Hippocratic Oath

Hippocrates, the founder of our profession, established the foundations of our discipline by an oath, in which a sacred principle is that a drug which can terminate a pregnancy should never be given or shown to a pregnant woman by any doctor, thereby shaping the bent of our education towards kindness from the beginning. For how much worse would he who forbade harming even the dubious potential of a man deem it to harm someone already born? Therefore, he judged it of great important that every physician, conforming himself to that principle, preserve the name and honor of medicine with a holy and pious spirit. For medicine is the science of healing and not harming. Unless he takes this idea to heart in his helping of the sick, the physician does not offer them the compassion that he promised. Therefore, as for those who do not wish, or are not able to assist the suffering, and who prevent others from doing so, let them cease from denying the sick the recourses which have been demonstrated so frequently through the power of medications!

Preface: On Choosing A Doctor

Now only rarely does anyone carefully consider the doctor when he hands himself or someone in his family over to that doctor's care, though no one would ever entrust the painting of his portrait to an artist without testing the artist by looking at examples of his work and choosing in that manner.... It is evident that there are certain people who value just about anything as much as they value their own [health].

Thus, the necessity for all [doctors] to study is eroded.

11: Chronic Headache

A live stingray placed on that part [of the head] which is in pain until the pain stops and the part goes numb immediately relieves and perpetually cures headache, however chronic and intolerable. As soon as [the patient] senses numbness, let the fish be removed, otherwise that part of the head will be numb forever. Many electric rays of this type should be obtained, since occasionally a cure (that is numbness, which is a proof of cure) appears after two or three [applications of the treatment].ⁱ

14, 16, 17: Epilepsy

(14) It is established among many that P1 or a *victoriatu*s of crocodile testicles taken with three cups of water for thirty days has cured many [from epilepsy].

(16) I know a certain good woman in Rome who has cured many of epilepsy by this medication:

1 small measure of ivory filings
1 pound of Attic honey
These are mixed together.

Afterwards, if it is a boy who suffers, the following ingredients are added: The blood of a male turtle, a male dove, and the blood of any recently captured wild beast – as much blood as flows out while each animal is still alive.

But if it is a girl who suffers, then the animals should be of the female sex, captured in the same way.

Let these animals be killed by bloodletting. It is important that a sharp nail of Cyprian bronze be stuck into the jugular vein of the turtle, and to incise the veins of the dove, which are beneath the wings, with sharp bronze.... There are even those who will drink blood from their own veins, or who will drink three spoonfuls of blood from a dead man for thirty days.

(17) Likewise, let them consume a part from the liver of a slain gladiator nine times. Whatever remedies of this sort exist fall outside the profession of medicine, however much they seem to be of benefit to other people.

22: Opium

I add opium to this mixture and to all salves, and my patients respond better. However, make sure to use that which comes from the pulp of the wild poppy flower, not from the leaves, like what the peddlers of unguents make for the sake of profit. The former is wrought with great labor in small quantities; the other is ground up without bother and [found] abundantly.

59: Toothpaste

[This is] a toothpaste which makes teeth shine brightly and makes them stronger: sprinkle a *sextarius* of barley with vinegar mixed with honey, and knead it thoroughly. Then divide [the mixture] into six globules. This done, a measure of salt dug up from the ground is mixed in. Cook this in an oven until it is rendered into charcoal. It will then be necessary to mix in nard, however much seems like enough.

84: Bleeding

It is imperative that the person seeing the wound place a sponge recently taken from water or harsh vinegar over it and to change [the sponge] frequently, lest it harm the wound by becoming too warm. It is also important to prevent the limb from being bound up, which many doctors do, not realizing that bleeding is aggravated by compression of the muscles. This is because all forms of compression in any part [of something] will cause more of the underlying material to spurt out. Just as is the case with a bag, if someone tightly ties the middle of the bag with a string, he will notice that the underlying material will move to another part. And if by chance there is a hole over [that part of the bag], whatever is inside it will be ejected with rapidity. For this same reason, when blood is spurting [from limbs] those who cinch [them], compressing the limbs with great force causes more blood in the veins to be lost through the wound. The evidence for this assertion is that if someone punctures a vein above a tourniquet in the limb of an animal, he will notice that blood is lost equally from that part as from a lower place when the vein is punctured. And if physicians do not see this plainly, they deserve to be blamed... since blood loss is aggravated by their ignorance. And, O God, these are the very ones who blame their failures on medicines, as if these weren't good for anything.

118: Ileus

Fenugreek, sent up through the anus, also works well for this disease. It is important to cook the fenugreek well in water and then to administer a measure. Likewise, it is important to cook rue in household oil and add to this a measure of the warm water I mentioned earlier. Into these you should mix in a smaller amount of saltpeter, and send it up warm through a syringe.

I myself once healed the slave of a certain merchant who sold perfumes by means of this medicine. He was already vomiting feces, so he otherwise would have died. Ileus is a very deadly disease indeed, and therefore is accounted among the most serious. For this reason, we should certainly not approach this kind of disease with a lot of confidence.

134: Dropsy

This medicine is of benefit for patients with dropsy, especially in the early stages of the disease, when the whole body is distended, a condition the Greeks call *ὑπόσarca*. Take:

P 20 of white bryony

P 4 of cooked mezereon

P 10 of scillaⁱⁱ bulb cooked with the exterior part having been peeled off

P 8 of myrrh

.... It is important during treatment to give the patient simple, rustic meat, or poultry, for food, with austere and simple wine.

180: Opium Overdose

When drunk, opium (which some call meconium) is recognized by its heavy odor, a property which it takes from the green poppy, of which it is the juice. It causes heaviness of the head, bruising and stiffness of the joints, and causes cold sweat to flow. It impedes respiration, fogs the mind, and makes one unconscious. Those who drink it should be helped with water and wine mixed together. This should be given over and over again, and [the patient] should be made to vomit frequently with either a feather or *lorum vomitorium*. A cup of wine is useful in these circumstances, and a measure of oil and raisins can be given for the same reason. Likewise, wine and vinegar in equal measures, mixed with a third measure of rosewater, are given, so that [the patient] will be compelled to vomit. Afterwards, the head should be covered in vinegar and rose water without delay, and the patient's feet be assiduously rubbed with dry hands or hands wrapped in rough cloth. Mustard and harsh vinegar, anointed around the feet and calves are useful, as well, and prevent sleep for a time, lest the patient becomes unconscious.

199: Accidental Leech Ingestion

When leeches, which some call blood suckers, have been eaten and are clinging to the upper throat, a great bother to that part of the body, and something most ticklish, then it is important to remove them with vinegar, as much as can be drunk.... Lumps of snow will also do the same thing, if taken in great quantities.

237: Wound Care

Honey,ⁱⁱⁱ either by itself, or dry iris ground up with honey, cleans dirty wounds in all parts of the body (by dirty, I mean when they become white, or become covered with a white crust).

Felipe Fernandez del Castillo is a member of the University of Massachusetts Medical School Class of 2016.

Endnotes:

- i. Electrotherapy for chronic migraine has been studied and reviewed.⁴
- ii. Plants in the *Scilla* family contain cardiac glycosides, and have been implicated in at least one case of fatal toxicity.⁵
- iii. Honey is an excellent antimicrobial and is still used in some settings.⁶

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Finishing the Game

Michael Hirsh, MD



Michael Hirsh, MD

Can a physician serve two masters? The new Will Smith/Alec Baldwin film asks this question and answers it with a resounding no.

In a compelling and often heartbreaking way, the story of Dr. Bennet Omalu, a forensic pathologist working at the Allegheny County Coroner's Office, illustrates how difficult it can be to let science lead the way to a truthful investigation when physicians serving as corporate

shills and powerful organizations bent on subverting the truth stand in the way. Dr. Omalu stumbles upon an autopsy of an iconic former Pittsburgh Steeler and football Hall of Famer Mike Webster, whose post-concussive injuries had left him homeless and psychotic.

Despite pressures to let things slide, Dr. Omalu recognizes the same type of pathological changes in the brain of Mr. Webster as was only previously seen in boxers. He calls the findings chronic traumatic encephalopathy (CTE) and thereby unleashes the NFL and its minions, who try to threaten, disgrace, discredit and obfuscate until Dr. Omalu is forced to leave Pittsburgh entirely. Even his supportive boss, a nationally known medical examiner Cyril Wecht, is accused of petty (later withdrawn) federal charges. Omalu's wife is harassed into a possible miscarriage. Of course, Dr. Omalu's righteousness in support of his theory stands out, but the viewer will be dismayed to see the number of MDs who forged unholy alliances (presumably with great compensation packages) with the NFL, even when the mounting evidence confirmed Dr. Omalu's hypothesis. The team doctors found that caring for the head-injured football player patient was at odds with team's interests – so they put the team first. The league's chief medical advisor was a rheumatologist who sought to dismiss the new theory with woefully inadequate NFL-subsidized studies that erroneously showed that football impacts did not cause concussions.

This is what I referred to earlier as serving two masters – in this case, trying to do right by both the players and the NFL and ending up serving both poorly. In 2011, the NFL settled a lawsuit with a group of 5,000 players, which included a codicil enforcing a gag order on the evidence those players brought to the trial. And by their own estimates, up to 28 percent of former NFL players will suffer from CTE before they die. Imagine the lost opportunity from a public health standpoint this gag order presents, as it stifles the ability to counsel parents and their eager youth about the true risks of participation in this contact sport of all contact sports

The greed and blatant disregard for the welfare of the people who play this game is obviously the NFL's true problem behind the "shield." But whenever physicians forget their Hippocratic Oath by failing to advocate for the patient's benefit and instead pursue their own self-aggrandizement (i.e., being an NFL team doc), the patient loses, as does our entire profession.

I urge anyone reading this to see *Concussion*. It is tight, well-scripted and well-acted. After 10 years in Pittsburgh, I knew many of the lead players in the tale personally and found their portrayals eerily accurate. Whatever your feelings about football, which the film acknowledges can be a graceful and beautifully athletic game, the film will give you new misgivings about the power of the NFL and how it can reach right into the halls of the FBI, the court system, Congress, the media and the doctor's office. The NFL seemed to model its actions after Big Tobacco, and just like smoking has deadly consequences, suppression of concussion facts has cost and will cost many young men their lives.

Mike Webster spoke about how the No. 1 goal of his career was "finish the game." Until the NFL owns up to its cover-up and the harm it knowingly inflicted on some of the best athletes anywhere, it has failed in that goal. And physicians should not contribute to this failure with the overt complicity this movie amply illustrated.

Michael P. Hirsh, MD, is the director of UMass Memorial Children's Medical Center Trauma Program; co-director of Injury Free Coalition of Worcester; medical director of Worcester Division of Public Health; and director of Goods For Guns Coalition of Greater Worcester.

A Legend Retires – Harvey G. Clermont, MD

Jane Lochrie, MD



It is hard to believe that after 20 years of tirelessly caring for the underserved in Central Massachusetts, Dr. Harvey “Jerry” Clermont is retiring. He has opened at least six free clinics in the Worcester area and has spent four nights a week working at these clinics since 1996, providing health care to patients who would otherwise not be able to receive care.

Irish Diplomacy is the art of telling someone to go to hell and making them look forward to the trip. Even though Jerry is not Irish, he somehow has this diplomacy. I always said Jerry could talk the devil into going to Mass. I have known Jerry since I was a medical student, and he was always my “go-to surgeon.” I think he should have been a primary care physician because he has a “primary care” personality. We worked many years together at Fallon Clinic, and because of his wonderful rapport with patients and families, every “difficult” patient was referred to him.

Inspired by Tom Dooley, who he heard speak while he was a student at Holy Cross, Jerry opened a branch of Heal the Children, an international organization that sends doctors to third-world countries. In 1986, he founded Children’s Health and Nutrition Goals through Education (C.H.A.N.G.E.), an organization that brought sick and malnourished children from around the world to Central Massachusetts to receive free medical care.



Jerry has spent his entire career taking care of the underserved and the most vulnerable patients, including missionary work in Guatemala, Ecuador and Nicaragua. He brought 36 children who needed surgery to the U.S. from Latin America. They stayed with him for weeks or months, and sometimes, he just adopted them.

He has three biological children and seven adopted children, five of whom are from Korea. One of the children he brought here for surgery from Guatemala called him several years later, when she was 14. She was pregnant at the time, and her family no longer wanted her. Typical of Jerry, he said, “Why don’t you come and live with us – you already know all my kids.”

Though Jerry does not want any recognition for the work that he has done, both domestically and internationally, he has won numerous awards for his unwavering commitment to taking care of the most disadvantaged patients. Anyone who knows Jerry will tell you that the most important part of his life is his extended family, especially his wife, to whom he has been married for 54 years, his children and all the students and people who volunteer with him, who he treats as his family.

In summary, Jerry is a living saint. We will all miss him greatly at St. Anne’s, but we hope he enjoys his retirement. It has been a privilege to work with him over the years.

St. Anne’s Free Medical Program is seeking volunteers to help staff the clinic Tuesdays at 6 p.m. The clinic is located at 130 Boston Turnpike, Shrewsbury. Please contact Lisa Izzo, executive director, at lisa.pinnow@gmail.com for more information.

2016 Annual Business Meeting

Worcester District Medical Society

Massachusetts Medical Society

2016 Community Clinician of the Year Award Recipient – Warren J. Ferguson, MD



Daniel Lasser, MD, MPH, Nominator, George Abraham, MD, Chair of WDMS Awards Committee, Warren J. Ferguson, MD, Award Recipient, Terrence R. Flotte, MD, Nominator, Frederic Baker, MD, President of WDMS



Warren J. Ferguson, MD, Award Recipient



Terrence R. Flotte, MD, Nominator



Daniel Lasser, MD, Nominator



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Arthur M. Pappas, MD

July 3, 1931- March 22, 2016

Dr. Pappas, 84, passed away March 22, 2016, with his family at his side. A native of Auburn, Dr. Pappas was the founding chairman of the Department of Orthopedics and Physical Rehabilitation at University of Massachusetts Medical Center and is fondly recalled as “the first UMMS surgeon,” having admitted and operated on the first patient in 1976 at what was then the newly constructed UMass Hospital.

He focused on the orthopedic care of handicapped children and professional and amateur athletes. A pioneer in the field of sports medicine, he published more than 100 articles related to orthopedic problems with children and athletes and has delivered more than 300 lectures worldwide. He was the medical director for the Boston Red Sox from 1978 to 2003; baseball Hall of Famer Carl Yastrzemski said, “I lived my dream. Many call it the impossible dream. Arthur Pappas was responsible for my dream. If it wasn’t for Arthur Pappas, I would not have had 3,000 hits and 400 home runs.”

Dr. Pappas was also a former president of the Association of Professional Baseball Physicians, a member of the Sports Medicine Committee for the American Academy of Pediatrics, president of the Massachusetts Amateur Sports Foundation and a sponsor of the Bay State Games.

For his cherished and lasting contributions, Dr. Pappas received an honorary degree from our medical school in 2011. He also received numerous awards, including the Massachusetts Medical Society Lifetime Achievement Award in 2011, Worcester District Medical Society’s Dr. A. Jane Fitzpatrick Community Service Award in 1999 and the Physician Achievement Award from the Arthritis Foundation in 2000. He was also presented with the Dr. Marian Ropes Award from the Arthritis Foundation. In 2003, multiple donors honored Dr. Pappas by establishing the Arthur M. Pappas, MD, Chair in Orthopedics at UMass Medical School.

He was a mentor to students to the end. In 2013, a grateful medical student credited Dr. Pappas, chair emeritus, for her chosen career path. She said, “He was amazing. He introduced me to orthopedic surgeons and helped set up an internship and shadowing opportunity for me.”

While famous as the “father of sports medicine,” Dr. Pappas’s true passion was the care of children with severe orthopedic challenges. He served on the Board of Trustees for the Massachusetts Hospital School for severely handicapped children. He was fond of the Forest Witcraft quote: “A hundred years from now, it will not matter what my bank account was, the sort of house I lived in, or the kind of car I drove... but the world may be different because I was important in the life of a child.”

Dr. Pappas and his wife, Martha Pappas, EdD, have long been highly regarded for their generosity and philanthropy. They received the 2012 Isaiah Thomas Award for leadership and philanthropy from the *Telegram & Gazette* for “dedicating a lifetime to improving their local community, as well as enriching education, health and recreation opportunities throughout the region.” The couple unveiled a youth athletic complex – the Arthur M. and Martha R. Pappas Recreation Complex – in their hometown of Auburn, which included Little League, softball and soccer fields; a playground for families and children; and a performance pavilion. In 2001, a renovated teaching amphitheater was formally dedicated to the couple for their philanthropy to the Medical School and the UMass Medicine Foundation.

For all his contributions to our organizations and the community, Dr. Pappas will be fondly remembered and sorely missed.

Eric W. Dickson, MD, president and CEO, UMass Memorial Health Care

Michael F. Collins, MD, senior vice president for the Health Sciences and chancellor, University of Massachusetts Medical School

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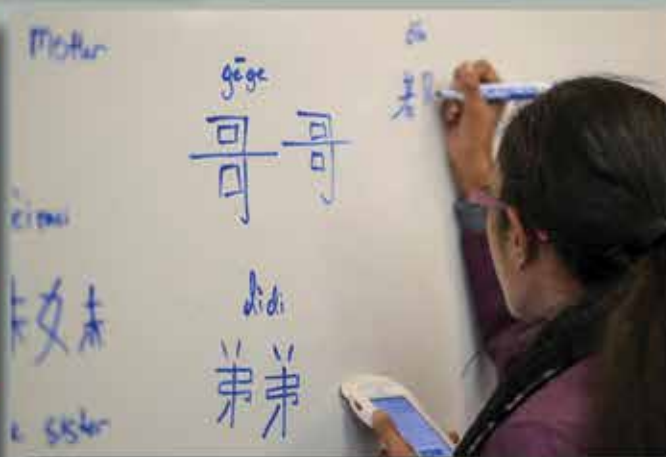
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