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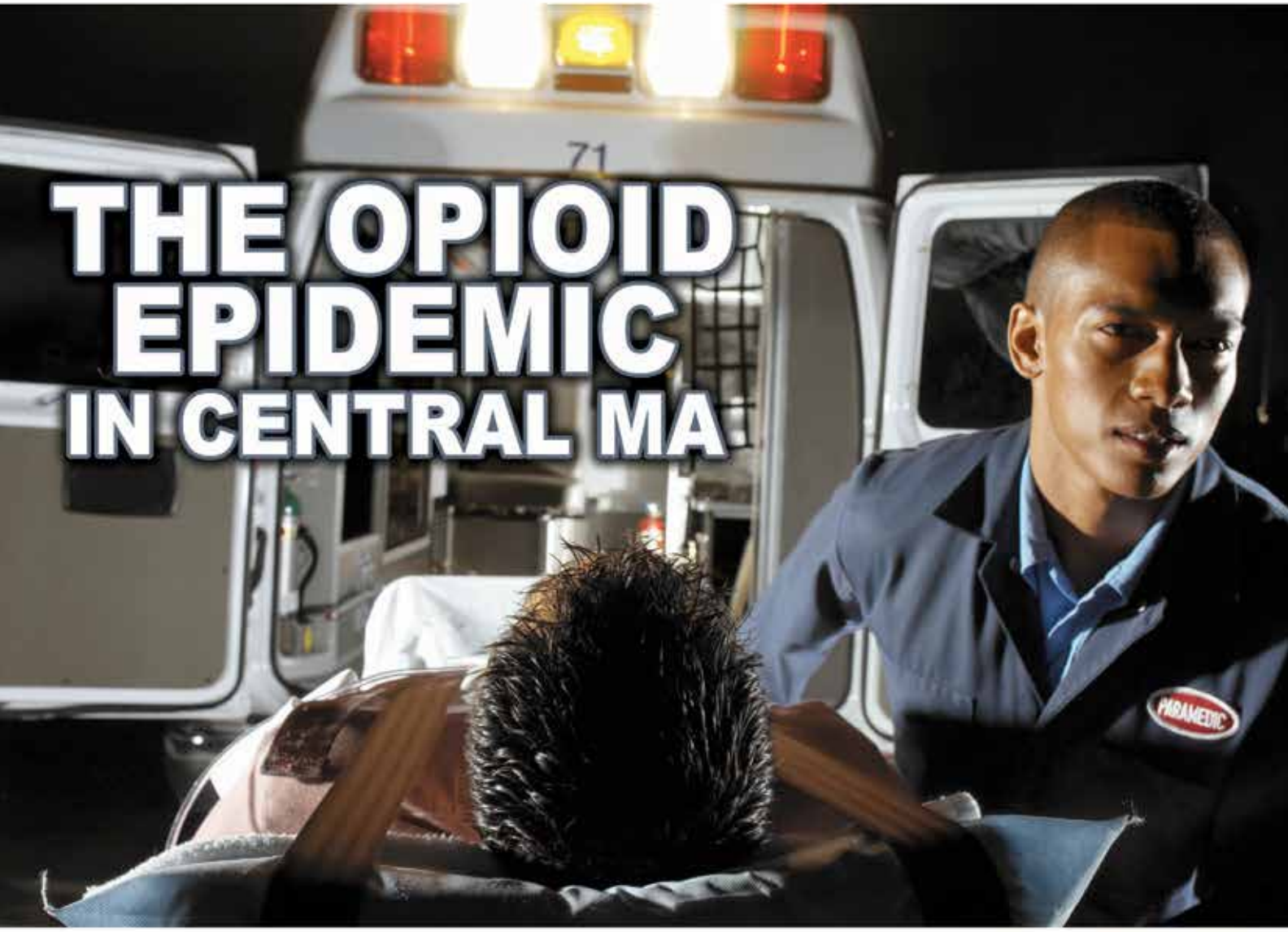

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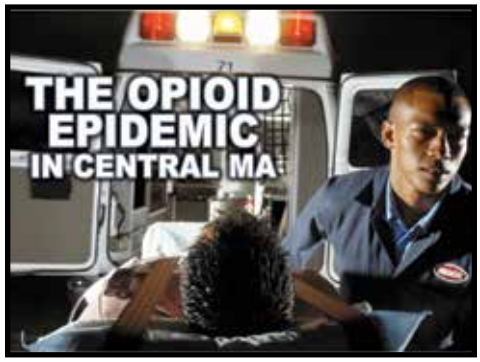

On the Cover:
The Opioid Epidemic in Central MA

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Editorial

Jane Lochrie, MD

Jane Lochrie, MD

Opioid overdose in Massachusetts has risen to a crisis situation. Two people in Massachusetts die every day from an overdose of this narcotic; more deaths are attributable to opioid use than car accidents. The number of babies born with opiates in their system in Massachusetts is triple the national rate. In March, Governor Deval Patrick declared opioid overdose and death a public health emergency.

Early in August, Worcester police responded to 33 overdoses, at least nine of them fatal, in a six-day period. Worcester first responders now carry and administer Narcan to suspected overdose victims. This issue of Worcester Medicine explores this increasing problem.

In the first article, Dr. Amy Harrington reminds us that there are several pharmacologic ways to treat addiction. In addition to medications, treatment should include psychological therapy, as well as engagement in recovery community support such as Narcotics Anonymous and Smart Recovery.

Kenneth Hetzler, M.D., the medical director of Adult Psychiatry at Salem Hospital insinuates that physicians do not have the expertise to help patients with addiction problems and may avoid dealing with the problem. This leads to low physician satisfaction and to less-than optimal clinical outcomes. He advocates that physicians should join the American Society for Addiction Medicine to develop a competence to treat these patients.

Third year medical student Miriam O'Neil takes us on her personal journey of deciding whether addiction is a disease or a moral failing. She concludes that addiction is not something that can be overcome by sheer willpower and that we all have prejudices about addicts that influence the way we treat these patients.

The newest opioid drug, Zohydro, is discussed by Matthew Metcalf, Pharm.D., Ph.D. He lauds the extended release form of hydrocodone for eliminating acetaminophen from its formulation and for giving pain specialists another choice in their "opioid tool ches,t" This new medication is not without drawbacks, the chief being there are no abuse deterrent formulation measures, and he discusses why he believes the drug was formulated in this manner.

In the final article, George Sherril, the chief of police in Holden, describes opiate abuse over the past few years as "abnormal and shocking." He appeals to the community to be proactive and requests more education, communication and information sharing.

Don't close this issue without reading Dr. John Zawacki's moving personal statement about being nominated for the Chancellor's Medal for Clinical Excellence. As always, Peter Martin, Esq., has written a very timely Legal Consult. This month, "The Legal Perils of Methadone Treatment" fits in perfectly with our theme articles. And in closing, after reading David Hatem's book review of One Doctor, Close Calls, Cold Cases and the Mysteries of Medicine, I have already downloaded it into my Kindle and can't wait to read it.

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When medical technology does not match demand

Frederic Baker, M.D.


Frederic Baker, MD

As a physician, I often marvel at how fortunate we are to have some of the greatest advances in medicine at our disposal, advances that were previously unimaginable a century, or even 20 years, ago. Technological advances once confined to the realm of science fiction such as antivirals, non-invasive imaging, minimally invasive surgical procedures, prosthetics, human genomic mapping, smartphone medical apps and 3D printers are just a few of the great examples.

Perhaps the area of medicine that offers some of the greatest promise, yet offers some of the greatest disappointment, is that of the electronic medical health records or EMRs/EHRs. According to Medical Economics, 67 percent of physicians dislike the functionality of their EHR systems. When physicians talk about EHRs, it can often evoke memories of the famous "Festivus" episode of Seinfeld. Conversations lapse into loud and passionate "airing of grievances," with calls for a rejection of the commercialism and "worship" seen in the marketing of EHRs; nostalgia for the simpler time of paper records; and expressions of disappointment directed at vendors and institutions who would impose their EHR beliefs on others.

Consumer Reports recently espoused how EHRs could revolutionize medicine by affording patients greater access, portability, accuracy and better outcomes through patient engagement. The U.S. federal government established five objectives for "Meaningful Use" to promote and implement in EHRs that include improving quality, safety and efficiency; reducing health disparities; engaging patients and families in their health care; improving care coordination; improving population and public health; and ensuring adequate privacy and security protections for personal health information. Much controversy arises, not from the goals, but from the policies designed to achieve those goals.

Although the federal government has made significant investments in providing financial incentives to adopt EMRs and financial disincentives/penalties for not adopting them, many physicians have noted the incentives are dwarfed by the enormous cost, burdens and disruptions that are imposed upon practices, which are already overwhelmed with competing and ever-expanding unfunded regulatory and administrative burdens. Recently Medscape noted 70 percent of national physician survey respondents said the EHR decreases their face-to-face time with patients and 57 percent said the EHR decreases their ability to see patients. A 2013 MMS survey found that among the almost 80 percent of Massachusetts physicians with access to an Electronic Health Record system, a full 66 percent reported that using a system slows down their practice of medicine. Another one-third indicated a related initial decrease in revenue.

Ideally, EHRs should function like any desirable technological advance: by significantly reducing the manual effort, cost, time and menial nature of completing repetitious tasks typically required of medicine and creating a process that allows for seamless patient-physician interactions, with minimal disruption and high satisfaction for all parties. Too often the opposite is true. Tasks such as documenting allergy profiles, coding, charge entry and responding to patient lab abnormalities or questions can often seem like tremendous burdens, consuming far more time to execute on the computer than on paper and transforming face-to-face visits into impersonal, prolonged computer interactions. For example, the simple and rapid process of entering an allergy profile on paper as "Allergy: Penicillin=Rash" can entail a painful process of multiple keystrokes, 15 mouse clicks and navigating through various windows one at a time on a computer, which prohibits multi-tasking, entailing more time than it might take to complete this entire paragraph. Either the

software engineers have a complete disregard for your time or we have a system that shows no consideration for efficiency. Is that progress?

Most physicians don't have the luxury to readily abandon inefficient EHR systems because they are legally bound and financially committed to expensive long-term contracts, thanks to demands made by the federal government. Much to the chagrin of many is the reality that data cannot be easily transferred or shared with another system. Some of our colleagues describe the horrors of upgrading an EMR package of a particular vendor to one with more features, or because their system is obsolete, only to learn that the two packages offered and made by the same vendor cannot communicate with each other. Some practices have embraced the use of scribes, trained professionals who receive and input patient data into the EMR prior to a physician's arrival. Advocates assert this model provides greater access, productivity and satisfaction, as physicians are freed from the time-consuming constraints of data retrieval. For a health care system that is allegedly obsessed with reducing administrative cost and simplifying care, it seems hard to fathom the logic and sustainability of a system that now demands having to hire more staff and require more data.

Many welcomed the federal government's decision to delay the transition of our disease classification system from ICD-9 to ICD-10, as some forecasts placed the costs at a minimum of $80,000 per physician, with massive disruptions of care and loss of practice revenues and productivity, with no immediate benefit for patients, in a system that is already struggling to meet with many competing and complex regulations. However, I found it most disturbing to hear one health software company executive lament the delay on NPR as "It's kind of like looking forward to Christmas, and it doesn't come." Clearly, not everyone's incentives are aligned at reducing cost and enhancing efficiency. Sadly, as many have noted, patients and doctors are at the mercy of medical software companies or third-party payers that have no incentive or mandate to pursue, develop and sustain programs that enhance usability, communication, end-user workflow and satisfaction.

Rather than impose more burdens on physicians and their patients to assume more risk, it would appear to make more sense to have the federal government incentivize insurers and software vendors, who have far more experience and input in health care system infrastructure, to comply with standards that would facilitate the most efficient workflows, both freeing and empowering highly trained and skilled health care professionals to do what they do best: treat and respond to patients first; data last.

I recall hearing past AAFP President Dr. Ted Epperly extol the wisdom of President Lincoln's administration's decision mandating U.S. railroad companies comply with a universal or standard railroad gauge or track dimensions in order to achieve the goal of a highly successful intercontinental railroad system. Prior to that, the U.S. had multiple track gauges, making it either prohibitively costly, wasteful or virtually impossible to share resources and effect efficient commerce between businesses, customers and railroad systems. Perhaps a similar model would serve us well with EHRs. As AMA president and health IT expert, Dr. Robert Wah, so eloquently noted, "Physicians will always embrace a technology that makes their work more effective and more efficient. They will always push back on any technology that gets in the way of providing better care for the patient." Organized medicine must be more assertive in demanding that our officials, third-party payers and EHR software vendors and developers support electronic health care systems that conform to the highest standards of workflow efficiency. We must reject those programs, policies and measures that are either unproven or wasteful. EMRs are tools, not outcomes, and must always serve and respond to the unique and ever-changing demands of the patient-physician relationship, not vice versa.

Please feel free to provide feedback and tell us about your experiences with your EHR at fgrillb@aol.com.

How satisfied are you with your EHR?

What would you recommend to enhance the current system?

What would you do away with?

Please note we cannot reply to all submissions. We will try to post excerpts on our website.

Please remember to protect patient privacy and refrain from sharing any type of patient protected information or identifiers, as this communication does not comply with HIPPA statutes.

Thank you.

Treating the Opioid Epidemic in Central Massachusetts

Amy L. Harrington, M.D.

Amy L. Harrington, M.D.

This past summer, an epidemic of heroin-related deaths in the Worcester area made news across the state. According to the Department of Public Health, more people in Massachusetts died from opioid overdoses than from motor vehicle accidents last year.[1] It is important for the medical community to address this problem from as many angles as possible, including preventing access to diverted opiates and encouraging patients and families to access appropriate medical resources.

In recent years, prescriptions for opiate pain medications have increased dramatically, and unfortunately, the death rate from opioid overdoses has increased at a parallel rate.[2] Many heroin users were first introduced to opiates through prescription pain medications, as there is often a perception that prescription medications are safer. Young people, in particular, are vulnerable to this misperception.

The treatment of patients with opioid dependence should consider including psychosocial treatments, medications and engagement in recovery community support. Office-based practices can include using a medication called buprenorphine. Buprenorphine is a partial opiate agonist that decreases cravings for opioids and can help reduce the use of illicit opiates. It is always important to stress that all medications need to be kept safe at patients' homes, but any medication that has abuse liability, such as opioid medications, should be kept in locked storage. Most home improvement stores sell lock boxes that fit into a standard medicine cabinet at a reasonable price.

Patients under our care are accustomed to a higher level of vigilance, making sure that the prescription of this opiate medication is safe. Thus, the prescriptions are to the exact day, so that patients who are seen again in 28 days will receive a prescription for 28 days and not 30. Urine toxicology screens and random pill counts are standard operating procedure. Clear and respectful explanation to the patients at the onset of treatment usually yields a good response and compliance. Most patients are understanding of the prescription practices in our clinic because they are included in the reasoning and decision-making. They often appreciate the extra effort physicians take to practice in a responsible manner, thereby helping them continue their recovery.

In addition to buprenorphine, there are several other pharmacologic ways of treating opioid dependence. Methadone is also prescribed for this reason; however, it is a full agonist. Treatment with methadone for opioid dependence can only be done in more strictly regulated, structured and licensed methadone maintenance clinics. Methadone can also be more effective at controlling cravings in people who have very high tolerance levels to opioids. Naltrexone is an opioid receptor antagonist that blocks the effects of opiates and can be given either as a daily pill or as a once-a-month injection. All the pharmacotherapy approaches should include recovery-oriented support and/or psychosocial treatment interventions.

Overdose from opiates is a very serious public health and clinical problem. An important new development to address this issue is the dissemination of intra-nasal bystander administered naloxone for reversing opioid overdoses. Like naltrexone, naloxone is also an opioid antagonist. Because it can be administered intra-nasally, it can temporarily reverse the effects of opioids, allowing enough time for emergency personnel to

respond. It is easy for even a lay-person to administer. Patients and their families are encouraged to be trained in how to use it so they can receive a prescription for the medication.

Many communities have been resistant to the prescription of intra-nasal naloxone, otherwise known by its brand-name Narcan, to people with active addictions. There is a misperception that the availability of this medication will lead to greater use of opiates. In fact, in communities where this medication is widely available, there are lower rates of overdose in the community[3], higher rates of people in drug treatment[4] and no evidence of an increase of the prevalence of Opioid Use Disorder[5], as was feared by opposition to this initiative.

In addition to medications, there are numerous psychosocial resources for drug treatment in Central Massachusetts. There are in-patient detoxification units where patients are weaned off of opiates over about five days. Patients completing detoxification are most likely to be successful if they have an after-care plan. Residential programs like halfway houses and therapeutic communities can be a few weeks or can last six to 12 months. Intensive out-patient programs allow patients to be in their homes at night but attend treatment during the day. Groups like Narcotics Anonymous and Smart Recovery are an important cornerstone for many people in recovery.

An unfortunate backlash to the opioid dependence epidemic in Massachusetts has been a fear of appropriate treatment of pain. Hopefully, as doctors become more aware of how to prescribe medications in a responsible way and as the public becomes more aware of the potential dangers, prescription opiates will stay out of the hands of young people and others who are using them in an addictive way. Appropriate disposal of prescription opioid medications that are not used will also reduce the availability of these medications and contribute to reducing the risk in the public.

In order to curb this epidemic, the medical community must address the issue from all angles. We must prescribe in a safe and responsible way. We need to tell our patients how to protect themselves from overdose and diversion. Finally, we should learn to recognize the signs of a potential problem and refer our patients quickly to effective psychosocial and medication treatment, including supporting patients' engagement in 12-step and other types of recovery support programs in the community.

Amy L. Harrington, M.D., is an assistant professor in the Department of Psychiatry, Division of Addiction Psychiatry at UMass Medical School and medical director of Acute Substance Abuse Continuum, Community Healthlink.

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Addiction Competence: An Action Plan for the General Practitioner

Kenneth A Hetzler, M.D., ABPN, ABAM

"To see patients without reading books is to set sail on uncharted seas. To read books without seeing patients is never to leave the harbor."

~ Sir William Osler

We've all of us left the harbor and are sailing on uncharted seas. Consider the following clinical vignette:

While your partner is on vacation, one of his patients ~ a young woman with chronic pain, fibromyalgia, depression and anxiety ~ presents in an anxious fluster, late Friday afternoon, just before the office is due to close, complaining that her prescription for Percocet "has run out," and stating "The pain makes me really depressed." She requests a refill. Consulting her chart, you note that she missed her last appointment, that she has recently been calling for early refills and at the last visit complained that "my Percocet isn't working for my pain anymore" and requested yet another dose increase.

This case reflects common a clinical dilemma. This young woman likely has prescription opioid abuse; in her case, compounded by the (undisclosed) need to share her medication with her heroin-abusing boyfriend. So, what is to be done?

Caring for the patient with addiction is a common, complicated and challenging experience for all physicians. Most of us did not have much exposure to addiction medicine in medical school or post-graduate training; it is not regularly a part of the most individual practitioner's continuing medical education programs, nor is it a topic in most hospitals' department grand rounds.

And yet, patients with addiction are over-represented in our practices. The addiction often exacerbates the presenting clinical problem and prevents effective treatment. Furthermore, there are few available resources for the practitioner. Most hospitals and groups do not employ "experts" in addiction; most physicians do not have colleague with addiction expertise to consult at the bedside or in the office. Referral sources are few; specialists generally have long waiting lists, and many of those are fastidious with respect to insurance.

This state of affairs puts many physicians in a state of anxiety and helpless frustration when confronted with addicted patients. These feelings may lead the physician to avoid paying attention to the addiction, to feel pessimistic about eventual outcomes (and therefore to do nothing) and, sadly, to dismiss the patients from their practices. Caring for patients with addiction unquestionably contributes to low physician satisfaction and to clinical outcomes that are less than optimal.

Like most practitioners, I received little formal education in addiction in medical school, and though, as a psychiatrist, I had somewhat more in postgraduate training, I was still utterly unprepared for the harsh clinical realities of practice.

Early in my career, ill-prepared and largely unaware of my own ignorance, I often missed addiction when it was present. Worse, I became frustrated and angry with those patients in whom I recognized addiction but who did not follow my directives ~ "stop drinking, don't use that, you are going to kill yourself, go to AA/NA" ~ which were well-intentioned but unhelpful. Worse still, I did not encourage these patients to stay in treatment; rather, I welcomed their departure. I felt badly when caring for them, their outcomes were poor and, consequently, my level of satisfaction in caring for them was very low.

This changed when ~ on the advice of a colleague ~ I made a mid-career decision to really educate myself about caring for these patients. I found a pathway to a much more satisfying and effective approach to working with them.

This pathway started when I joined the American Society for Addiction Medicine (ASAM). Over time, the educational resources available through ASAM helped me become a much more effective physician in caring for these patients. Caring for them is now the most interesting and satisfying part of my practice.

Fortunately, this pathway is open to all physicians ~ internists, ER physicians, family physicians, intensivists and surgeons. It offers the opportunity for each individual physician, regardless of training and discipline, to develop the competence to manage many patients within the practice and significantly improve clinical outcomes. It will transform the emotional experience of caring for addicted patients from one of anxiety and helpless frustration into one of calm confidence ~ even enjoyment ~ and professional fulfillment.

When I tell colleagues about ASAM, they of course ask: What is ASAM?

It is a professional society representing more than 3,000 physicians and associated professionals dedicated to increasing access and improving the quality of addiction treatment; educating physicians, other medical professionals and the public; supporting research and prevention; and promoting the appropriate role of physicians in the care of patients with addictions.1

When my colleagues go to the ASAM website, they are surprised to find the wealth of information and educational opportunities that are now at their fingertips.

So what is the action plan? In brief, with a timeline for implementation, I recommend that you consider doing the following:

Yesterday: You've already started; you've done what Osler asked; you've already cared for many patients; you've "left the harbor"; and though it hasn't always been fun, you've done it.

Now: At this very moment, read the ASAM definition of addiction at http://www.asam.org/for-the-public/definition-of-addiction.

Today: Join the American Society of Addiction Medicine at www.ASAM.org.

Tomorrow: Submit to the Oslerian discipline of Case Related Reading regarding your addicted patients.

Reflection. "If you want to learn medicine, see a patient and then read the chapter about that patient in your textbook. When you place a face on the chapter, you will never forget what you've read. The leading minds of our field have spent a lot of time preparing and organizing the information, take advantage of it."

~The late Ronald Fegelman. M.D., surgeon and teacher.
Buy the ASAM textbook Principles of Addiction Medicine2.
While waiting on the textbook ,use the ASAM online resources.
Read about one patient/week ~ "When you place a face on the chapter, you will never forget…"

This week: Keep up your momentum.

Organize resources. Put useful websites on your browser favorites bar.

American Society of Addiction Medicine (ASAM) 1
Massachusetts Chapter, ASAM3
National Institute on Drug Abuse (NIDA)4
Alcoholics Anonymous (AA)5
Narcotics Anonymous (NA)6
Drug Abuse Warning Network (DAWN)7

Seek support. Talk to your chairman and/or partners about devoting time to addiction medicine and even the possibility of becoming your department/group champion.

Next week: Identify a CME meeting about addiction medicine (see ASAM and Harvard Medical School websites) and add it to your CME plan.

Next year: Consider a stretch goal, such as anAmerican Board of Addiction Medicine (ABAM) Certification.8

Kenneth A Hetzler, M.D., ABPN, ABAM, is the medical director of Adult Psychiatry, Salem Hospital NSMC, Partners Healthcare.

References:

American Society of Addiction Medicine Website,~ www.ASAM.org

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Massachusetts Chapter, American Society of Addiction Medicine (MASAM), www.masam.org
National Institute on Drug Abuse (NIDA), www.drugabuse.gov
Alcoholics Anonymous, www.aa.org
Narcotics Anonymous,www.na.org
Drug Abuse Warning Network, www.samhsa.gov/data/
American Board of Addiction Medicine, www.abam.net

Food For Thought

Miriam P. O'Neil, JD, LL.M.

Miriam P. O'Neil, JD, LL.M.

Let's talk about addiction. Is it a disease or a moral failing? What personal bias do you bring into the room?

That's alright. I'll go first.
During the summer after my MS1 year, I attended an immersive week-long training program at The Betty Ford Center, a renowned addiction treatment facility. In my application essay, I shared the following and do so now in order to provide a sense of my attitude toward addiction as I began the week:

Although I have never heard anyone in my family refer to him as such, my uncle John was an alcoholic. He died at 46, leaving two sons under the age of 7 without a father. So many things changed or, perhaps more accurately, were accelerated the day he died. John's sons grew up physically, yet continue to struggle to find themselves. Patrick, his youngest, learned to hate himself because he looked like his father and had a bit of the same personality; something his mother, still reeling from the pain and abandonment of life with an alcoholic, never let him forget. As an extended family, we fragmented. Holiday gatherings stopped, and we became mere acquaintances. My father lost his best friend and was never the same. It was as if some degree of innocence/joy had been taken from him. I was too young to really know John or to appreciate the complexity of history that brought him ~ yellowed, bloated, and dying ~ to that hospital bed. Its imprint, though, 27 years later continues to transform and remind.

In between Christmas and New Year's Eve, I attended an AA meeting in preparation for one of my January courses. In digesting the experience, my thoughts turned to John and the tremendous potential he had in life, not just to the rest of us out here in society but more intimately to his children, wife and brother. What happened? What if he had acknowledged his alcoholism and sought treatment? What if? With the accumulation of life, friends and experience, I have come to recognize that addiction, with its tendencies and triggers, is unfortunately rather common. Denial, guilt, shame and fear are used to justify and tolerate, allowing underlying emotional wounds and/or mental illness to fester and rob.

And so, I stepped off a plane at 9 p.m. in Palm Springs, Calif.,greeted by 121 degrees of heat. Dry heat, of course. The next evening at the official meet and greet, we were instructed to share why we had opted to dedicate a week of 12-plus hour days to addiction medicine. The gist of my response was that I believe we are all vulnerable, either personally or by proxy, to the consequences of addiction and that I had made a commitment to be a physician in order to gain perspective, knowledge and skills to help others transform past their suffering. Simply put, I was there to soak it in and learn.

During the week, as I sat in small group therapy knee to knee with eight women absorbing impressions of their lives and recovery, I began turning the concept of addiction as a disease in my mind. At what point did taking a drink, pill or hit stop being a choice and become a compulsion? Where is the line? Was a loved one simply to forgive the lying, stealing, betrayal and abuse because addiction is a disease? What responsibility did the individual have in this whole process? How does this disease differ from others, such as those borne from the myriad consequences of obesity or smoking? Each begins with a series of volitional acts.

As the week progressed, I was no closer to wrapping my mind around the concept. Then, a group member provided a new perspective. He was very successful in life and business with all the accoutrements ~ a beautiful family, happy marriage, multiple homes, private jet, etc. Every night, he drank until 1 a.m. and then was up at 6 a.m. working out with his trainer. One day, in the midst of an argument with his teenage son, he realized

that he had become his alcoholic father. In his characteristic approach to life, he identified the problem and took swift action; he quit drinking on the spot.

A year later, he walked into his doctor's office and said "One of three things is going to happen: I'm either going to start drinking again, kill myself or enter rehab." Without that intervening year of being a dry alcoholic, he stated he never would have accepted that addiction is a disease and something outside of his complete control to solve. No one could tell him. He had to painstakingly prove it to himself. The power of this story for me is that: (1) addiction is not simply a selfish bad habit that can be overcome by sheer willpower and discipline; and (2) I had been (and probably still am) holding prejudices about addicts, no doubt a shadow of a paradigm imbued with value judgments from childhood and designed to protect from addiction. Beliefs and thoughts, particularly those not yet fully brought to conscious awareness, subtly and overtly direct action and impact.

Now as an MS3, I've begun clinical rotations. This week during a discussion about difficult patients, our attending said the following (paraphrased): Pay attention to your impression of the patient when you first come into the room, particularly if you have a strong visceral reaction. That's when you need to lean in and listen more carefully in order to be the physician that you aspired to be the day you received your medical school acceptance letter, took your oath and entered residency. The rest is noise and does no one any good.

Now, it's your turn. Is addiction a disease or a moral failing? When you least want to, do you lean in?

Miriam P. O'Neil, JD, LL.M., is a third year medical student at The University of Massachusetts Medical School. Comments may be sent to Miriam.O'Neil@UMassMed.edu.

Understanding the Hydrocodone Formulation Challenge

Matthew D. Metcalf, Pharm.D., Ph.D.

Matthew D. Metcalf, Pharm.D., Ph.D.

One of the most interesting questions I've been frequently asked this year is "What do you think about Zohydro?" Coming from a strong background in pharmacy and opioid medicinal chemistry, my opinion on the drug is complex. In this article, I will attempt to provide a few points of consideration, which can provoke conversations with both other health professionals and your lay audience.

Zohydro is a new (2014), 12-hour extended release (ER) analgesic formulation of the opioid agonist hydrocodone. The main indication for Zohydro is the treatment of pain in patients who require constant analgesia on a long-term basis. Since it contains a potent opioid agonist, the drug is scheduled. This formulation, in addition to containing no other active ingredients, does not incorporate measures designed to limit abuse such as crush resistance or extraction resistance. The drug is analogous to the original Oxycontin formulation of oxycodone. Because of the contentious perceptions of Oxycontin use and abuse in current society, Zohydro is experiencing intense scrutiny and parallel controversy.

The Zohydro formulation of hydrocodone is laudable for several reasons. The first of which is the exclusion of acetaminophen from the formulation. The elimination of a toxic limitation found in all current immediate release (IR) formulations of hydrocodone eases most concerns of toxicity surrounding escalating opioid doses in pain management. A simple Internet search will produce many articles expounding the benefits and virtues of elimination of acetaminophen from the opioid formulation, and this point is highly touted by the manufacturer Zogenix. Adding another active drug to any formulation, without necessity, increases pharmacological complexity and adds potential for unintended clinical consequences. Ideally, the physician should have IR forms of all (opioid) drugs without a second drug (here acetaminophen) to simplify clinical decision-making. Zohydro, though an ER formulation, is a good step in that direction.

Another, and in my opinion superior, reason to praise Zohydro is for providing another tool in the opioid analgesic tool chest for chronic pain management. Though hydrocodone and oxycodone are both epoxymorphinans, similar in pharmacophore, they display slightly different (pre-clinical) efficacy and (both pre-clinical and clinical) potency profiles. Where these differences pose the most benefit in the clinic is in analgesic rotation to limit the development of tolerance. It is not difficult to envision a clinical study where simply inserting another opioid into a current rotation schedule could further reduce the development of tolerance. My background in opioid research suggests that the natural progression of clinical experimentation will soon produce studies demonstrating Zohydro is a valuable addition to opioid rotation schedules. I believe this product is valuable for pain specialists to have in their arsenal and will alleviate the suffering of countless patients who need to take strong opioid analgesics.

However, the Zohydro formulation is not without its significant

drawbacks. The chief concern is the lack of abuse deterrent formulation measures. Oxycontin (extended release oxycodone) was originally formulated in an analogous manner to Zohydro, with no abuse deterrents, but reformulated to include deterrents as the standard product. Zogenix and the FDA point to several important (non-formulation) steps that have been taken to limit abuse: the Schedule II status of the drug (other current hydrocodone formulations are Schedule III), indication for prescription is restricted to chronic-needs pain patients, and special post-marketing study and surveillance set up by Zogenix. While these points are positive in terms of preventing abuse (Schedule II status of pure hydrocodone products was mandated under law and not the company's choice), the glaring question is, why did the company not make an abuse-resistant formulation?

A conspiratorial (and paranoid) psychology might suggest the company intended the drug to be easily abused and intentionally left out the abuse deterrent systems to establish its brand amongst the abuse black market as a desirable product. While fanciful, I do not ascribe to such thinking. (No corporation would make this decision, if for no other reason than they would be liable for it.) Instead, I would suggest considering a more pragmatic possible explanation for the lack of abuse deterrents in the formulation. The drug business, at the end of the day, is a business, and it must make a profit. In the extremely competitive drug manufacture arena, typically you must be first to market (especially when using a non-patentable drug like hydrocodone) to establish the brand (innovator) product and dominant market share. To illustrate the importance of being first, ask yourself this question: Do we commonly call generic hydrocodone/acetaminophen "Vicodin" or do we call it "Lortab"? Vicodin was first to market. I suspect in 25 years, we will likely call ER hydrocodone "Zohydro" because it was first.

Zogenix was first among several competing companies to deliver an ER form of analgesic hydrocodone. To be first to market, Zogenix had to use the most efficient process possible. Since its formulation did not contain an abuse-resistance component, it did not need to spend the extra time needed to conduct studies on abuse deterrents. Zogenix got to market first and established the Zohydro brand. Consider the implications of timing when Purdue Pharma (makers of Oxycontin) announced that itssuccessful Phase 3 clinical trial for an abuse-resistant formulation of ER hydrocodone the same month that Zohydro hit the market. Even though the company had all the in-house experience with Oxycontin abuse-resistant formulation to speed up its product development compared to the competition, it was still second in completing its studies. Did this additional time for the abuse-resistance studies delay Purdue Pharma just long enough for Zogenix to establish Zohydro as the innovator product?

If you think Purdue Pharma does not make smart business decisions with opioids, think about the case of Oxycontin abuse-resistant formulations. Purdue Pharma updated Oxycontin to the abuse-resistant formulation (and withdrew the original formulation from the market) just shy of three years before its patent expired (the abuse-resistant formulation is patented controlled until 2025). This move prevented its competitors from selling generic formulations of ER oxycodone without resistance deterrents. This market monopoly technique was reminiscent of the withdraw of Schering-Plough's brand name Claritin from the prescription market (moving to the OTC market and replaced with brand Desloratadine with no competition) before its patent expired, leaving competitors with no innovator product on the market to sell generic loratadine on the prescription market. Both moves were strategic business decisions, which resulted in the corporations benefiting from additional patent protection, something that drug companies have done for decades, always with a new twist.

Business will be business at the end of the day; opioid product or not, executives will make a financial decision in the best interest of the corporation. However, I suggest you don't judge too harshly; without drug companies making profits, we could not have our current system of Western medicine. While not perfect, the current system of Western medicine is something I believe makes the world a better place. In the end, we are talking about an opioid drug formulation, not the drug. A formulation can be changed, and Oxycontin is a great example of this possibility. I believe that Zogenix will reformulate to an abuse-resistant Zohydro formulation, sooner rather than later. This move will increase the company's public support and keep an important pharmacological tool on the market for pain specialists to prescribe. Isn't that the goal ~ to eliminate the suffering in patients suffering from chronic pain?

Matthew D. Metcalf, Pharm.D., Ph.D. is an assistant professor of Medicinal Chemistry, Department of Pharmaceutical Sciences, MCPHS University School of Pharmacy at Worcester.

A Police Perspective on a 2014 Public Health Emergency

George R. Sherrill


George R. Sherrill

After 40 years of law enforcement experience in the Worcester County area ~ the last fifteen years as police chief in Holden ~ I have seen the various "hot topics" and "hot issues" during my career. Issues such as domestic abuse, drunk driving, elder abuse and sexual assault have all been problems that all law enforcement has had to cope with, no matter what the size of the community.

In the last four years, the reappearance of opiate abuse is at an abnormal and shocking level. Opiate abuse is every community's problem and not just limited to the urban environment and something that can be swept under the rug. The fallout of opiate abuse is an increase of crime in the community, as addicts need money and goods to feed their addiction. The toll on addicts' families is also an element that cannot be measured, as these families struggle to deal with their loved ones' pain and suffering.

The "war on drugs," as depicted by national leaders, has been a complete failure. Proactive measures that deal with prevention, education and treatment should be the real solution and focus. More money is spent on interdiction than prevention and treatment combined.

Just this past year, 1,300 babies were born in Massachusetts with narcotics in their systems. This rate is triple the national average. Why is this happening in Massachusetts? According to a June 10 Boston Globe article, "Reasons for the high rates of opiate abuse in New England range from overprescribing by doctors and drug dealers in major urban areas recognizing untapped markets, to a lack of detox beds and treatment programs. Also, as oxycodone abuse has dropped, suppliers have increased the availability of low cost heroin."

As a local police chief, I know that crime knows no borders. Those criminals that are breaking into homes in Worcester will also travel to area towns to commit their crimes and feed their habits. As this article is being written, there have been eight drug deaths in Worcester in just the first five days of August. On a personal note, I will never forget the death of my close friend, Paxton Police Chief Robert Mortell, who was killed on Feb. 1, 1994, as he backed up his fellow officers in Holden to assist in the capture of some burglars who were looking for some petty goods to fuel their drug habits. I have seen firsthand those relatives that struggle with the addiction of a loved one as they try desperately to find the magic "cure" for the individual. Many times, the family will seek a medical "Section 35" on that individual, and the police are called to serve that process and bring that person to a treatment facility. I have seen firsthand the pain and anger families feel when they return to a home that has been broken into and their sense of safety and privacy is no more. In most cases, these break-ins are perpetrated by individuals looking for jewelry, money and goods that can be disposed of quickly, so that drugs can be purchased for their addiction.

On June 17, Massachusetts Governor Deval Patrick met with the New England governors to address the recent overdose crisis. Since November, more than 200 people in Massachsuetts alone have died from opioid overdose. The working group agreed to work across state borders to better monitor the prescription of opiod painkillers and explore sharing of prescription data in part to curb "doctor shopping." The working group also vowed to push for mandatory registration in the Prescription Moni-

toring Program, an online database that medical professionals can check for the prescription history of patients.

In Vermont, the drug overdose issue has reached such a level that Governor Peter Shumlin devoted his entire State of the State address to the issue. In picturesque and quaint Cape Cod, heroin has flooded the 15 small towns in Barnstable County to the point that many of the police and fire departments carry narcan in their emergency vehicles. On July 30, a tourist in Dennis was pricked in the big toe by a discarded needle in a beach parking lot. The heroin follows the I-95 corridor into Providence, but then makes its way to Fall River, New Bedford and then Cape Cod. The Barnstable County sheriff has started using Vivitrol to assist those drug dependant inmates with a transition into the community. Vivitrol is a non-mood altering and non-addictive drug and is being used by other sheriffs in New York, Ohio and Maine. Per the Drug Enforcement Agency, what is causing the spike in deaths is the introduction of fentanyl into the mix. This drug is 30 times more powerful than heroin and is used to treat terminally ill cancer patients.

Drug use and addiction is a community problem and should be dealt with in all aspects of a community and not just left for the local police department to pick up the pieces when a crime occurs and things go wrong. By the time an individual or problem reaches the police level, it is too late. It is far better to be proactive and reach all segments of our society via education, communication and information sharing.

Chief George R. Sherrill has been with the Holden Massachusetts Police Department for 40 years, the last 15 as chief of police. He recently retired and is now assistant director of Public Safety at Mass College of Pharmacy and Health Science in Worcester.

The Legal Perils of Methadone Treatment

Peter J. Martin, Esq.

Peter J. Martin, Esq.

It is well-established in Massachusetts that a health care practitioner has a duty to warn his patient about the effects of medication and that the practitioner may be liable for harms to third persons caused by the patient resulting from medication-related impairment if the warning was not provided. At the same time, Massachusetts courts have been reluctant to extend liability to third parties for a physician's failure to meet his/her duty of reasonable care in treating the patient. However, a recent Superior Court decision in Vasquez et al. v. Community Health Care, Inc., a case involving care of a patient at a methadone clinic, argues for extending liability to third parties for both an allegedly inadequate warning and substandard treatment. While the decision is in no way precedential, it does contain an interesting discussion of how the particulars of methadone clinic treatment may support a further expansion of third-party liability for the allegedly sub-standard activities of health care providers.

The case involved an automobile accident where the patient of an outpatient opioid addiction treatment center, whose methadone dosage had been increased two days earlier, was involved in a fatal motor vehicle accident, resulting in two deaths and two injuries. The decedents' representatives brought suit against the treatment center, alleging that it breached three duties to the patient: its duty to warn the patient about the effects of the methadone on his ability to drive, its duty to administer methadone treatment adequately, and its duty to prevent the patient from driving under the circumstances. These three theories of liability were heard under a motion for summary judgment filed by the defendant treatment center. To be successful, such a motion must surmount a high threshold ~ the defendant must demonstrate there is no genuine issue as to any material fact and the defendant is entitled to judgment as a matter of law, and in reviewing the motion, the court must view the evidence in the light most favorable to the other party. In this case, the court upheld the motion as to the claim the treatment center should have controlled the patient by preventing him from driving, but denied the motion as to the claims of inadequate warning and substandard care. The court's decision basically means the judge felt these claims ought to be heard by the jury and were not barred as a matter of law.

In 2007, the Massachusetts Supreme Judicial Court in Coombs v. Florio ruled that a physician owes a limited duty to third persons who are foreseeably at risk from a patient's decision to drive and to warn the patient about the known side effects of medication prescribed by the physician that might impair the patient's ability to drive. How exactly this duty to warn was to be met was not described in detail by the SJC in Coombs. The Vasquez court evaluated the adequacy of such warnings in the context of the operations of a methadone treatment clinic.

The Vasquez judge considered the evidence of various warnings issued by the clinic to the patient over the 2½ months of his treatment. These included a consent form signed upon intake, notations in the medical record that the patient had been advised as to the sedating effects of methadone and that he should not drive during the three days after being administered an increased methadone dosage, and a sign next to a window where doses were administered that repeated the warnings found on the consent form. The court credited the patient's testimony that he did not remember being warned not to drive or about the sedative effects of methadone. It noted that during the course of treatment, the patient's methadone dosage was increased in multiple steps, but at each such increase, no new warning was issued to the patient. It also noted that the patient was non-compliant during the course of his treatment, having tested positive twice for illicit drug use and repeatedly failing to attend counseling sessions. The court concluded that it was up to the jury to decide whether the treatment center breached

its duty to warn by failing to issue one or more new warnings to the patient during the course of his treatment, or at least when his dosage was last increased, two days before the fatal accident.

This "refreshed warning" rule, if adopted by the courts, could lead to significant changes in how substance abuse treatment facilities counsel their patients, particularly regarding treatments involving graduated increases in medication dosages. It suggests that non-compliant patients may require even more frequent and documented warnings.

The Vasquez court's ruling as to the second duty,that of reasonable care, is potentially even more far-reaching, should it become Massachusetts law. Other courts have been unwilling to extend liability for negligent patient care beyond the patient to unrelated non-patient third parties. This unwillingness is in part due to the courts' desire not to impinge on the physician-patient relationship by inserting considerations about how a communication with a patient might serve to protect the physician from third-party liability.

The Vasquez decision, however, distinguishes between the traditional physician-patient relationship, which would be damaged by expanding liability for breaches of the duty of reasonable care to third parties, and the methadone treatment context, which presents "a unique somewhat non-traditional doctor-patient relationship, one that is characterized by minimal direct contact between the two and a heightened risk to third parties in the event of a breach of the standard of care. [The defendant] is a high-volume clinic that dispenses methadone to hundreds of patients a day, typically with no contact whatsoever between the patients and a doctor." The court also noted that since the patients are addicts, they present a higher risk of impaired driving, and the case ought to be analyzed not so much in the physician-patient context, but as in some non-medical contexts, such as liquor sales cases.

The practical outcome on methadone clinics of a new legal rule imposing third-party liability for breaches of the duty of reasonable care owed to the patient could be extremely far-reaching. The Vasquez plaintiffs offered expert testimony as to a variety of alleged shortcomings in the care of the patient in the case, such as delegation of dosing decisions to counselors and nurses and not to physicians; adoption of non-patient specific standing medical orders; methadone dosage change orders issued by LPNs without reviewing treatment notes; toxicology results or other relevant information; and the failure to tailor an individual drug-screening program for the patient.

While the case does not increase the standard of care for methadone clinics, the expansion of liability to foreseeably affected third parties for failing to meet that standard is significant. Increasing costs for methadone clinics, for example for professional liability insurance, could lead some clinics to close, perhaps not the optimum public health outcome in the midst of what has been described as an "epidemic" of opioid addiction. The Vasquez court acknowledged this danger, saying that "if it believed that the extension of liability to third parties who are foreseeably harmed by a breach of a clinic's standard of care to one of its patients would result in the shuttering of such clinics, it would strike the balance against such extension." However, the court discounted the likelihood of such an outcome. If upheld, only time will tell if this newly expanded scope of liability for negligent care at methadone clinics will improve care at such clinics or lead to their demise.

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

Personal Statement on Being Nominated for the Chancellor's Medal for Clinical Excellence

John Zawacki, M.D.

EDITOR'S NOTE: *Dr. John Zawacki has shared the unique circumstances which led to his calling to medicine in his talks for medical students and in his submission as a finalist for the coveted annual University of Massachusetts Medical School Chancellor's Medal for Excellence in Clinical Care. With Dr. Zawacki's permission, we have published his personal story for you. We hope you find it moving and inspirational.*

Years ago, Robert Fulghum wrote a best-selling book titled, All I Really Need to Know I Learned in Kindergarten. Well, similarly, much of what I needed to know about being a physician I learned at from my father as a young man. Medical school, residency and fellowship taught me what I needed to know to be an excellent physician, but it was Dad who taught me how to be an excellent physician.

I grew up in a gated community. As a boy, it seemed like a vast expanse, which included a large farm, several wooded hills and forests and a river which formed its most eastern boundary. These several hundred acres were enclosed by an 8-foot tall stone wall with two small entrances, each guarded by 10-foot tall blocks of granite to which were attached two large iron gates which could swing close. I grew up on the grounds of the State Lunatic Asylum in Taunton, Mass., which is now called the Taunton State Hospital (TSH), but which my boyhood friends called, "The Nut House." This June marks the beginning of my 40th year at UMass, Worcester, a campus built on what was the farm of the Worcester State Hospital. As a young man, I would have never imagined that I would spend the majority of my life living and working on the grounds of a state hospital, but doing so has been a blessing.

Dad, from the early 1940s until the early 1960s, was the assistant superintendent of the TSH. During the day, he was primarily responsible for assessing and treating the mental health of more than 1,500 residents. At night and during the daytime on weekends, he had a private psychiatric practice, with his office in our home. For more than two decades, my dad modeled for me daily how to be a physician.

Our hallway was his waiting room, and from an early age, I was encouraged to greet anyone sitting there and to say "good night" whenever I passed through on my way to bed. Dad was constantly on call. The phone rang regularly during dinner and family time, as well as during office hours. Seemingly, there was always someone needing help. Dad showed me again and again what it means to be available to help someone with a need and to provide continuity of care. As a young boy, I remember asking him why people needed a psychiatrist. I will never forget his answer: "Johnny, everyone needs a caring listener some time during their lives." How true.

I grew up not associating a stigma with mental illness. Wealth, being well-known and societal influence mattered not to Dad. All were equal in his eyes. He once told me that if I ever thought that I was better than another person, "I will kick the crap out of you." I like to joke about that incident, saying that this was pretty directive counseling coming from a psychiatrist, but that statement planted a lesson into the marrow of my being, a lesson which echoes clearly when I encounter a down and out alcoholic, a tattooed and multiply pierced drug addict, a handcuffed and shackled prisoner from the Devens fa-

cility, indeed, any patient I meet for the first time: "John, have infinite respect for every human being."

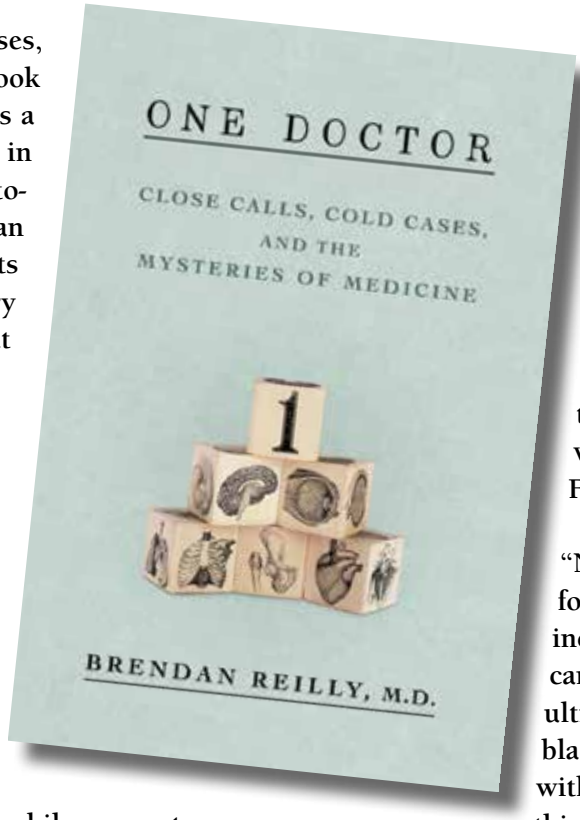
I especially remember the evening when I was descending the stairs leading to our hallway when a young high school girl burst through the French doors separating our living room and Dad's office from the waiting area. She was screaming at the top of her lungs. My dad followed her into the hallway, accompanied by her parents, gently speaking her name, "Nancy." She persisted in yelling at him, but Dad just tenderly and caringly uttered her name. She then hit him in the face with a closed fist, but Dad never flinched. He simply continued to talk calmly to her until she collapsed into his arms sobbing. I have never witnessed a more dramatic example of caring for one's patient. Dad was an easy-going, soft-spoken, deeply compassionate man who housed a heart large enough to care for a multitude. A few years after he died, we were legally allowed to destroy his records. They numbered in the thousands, and all were handwritten. It made no difference who you were, what you did or whether you could pay or not; if you had a problem, Dad was there.

During my college years, I expressed an interest in becoming a physician; Dad placed me on the back wards of the state hospital caring for a group of men who were incapable of caring for themselves. I washed, fed and cleaned up after these men for one summer. Throughout that summer, my dad would remind me, "Remember, when you become a caregiver, there is no job that is beneath you."

I could continue to regale you with stories about Dad. Suffice it to say, he showed me how to be a physician. You can be a font of information, a brilliant diagnostician and an eminent therapist ~ all these are in important in being an excellent clinician ~ but what is more important is to find ways to remain other-centered and patient-focused. Self-interest, self-importance and self-centeredness dampens caring and compassion. Respect, caring, listening, informing, and most important, taking the time and making the effort to journey with patients during the time of their illness is, in my mind, how best to be a physician. I will be forever grateful for being blessed with a father who modeled those values for me daily. I have tried for the past 46 years to emulate my dad, hoping to honor him by doing so.

One Doctor: Close Calls, Cold Cases, and the Mysteries of Medicine

David Hatem, M.D.



One Doctor: Close Calls, Cold Cases, and the Mysteries of Medicine, a book written by Brendan Reilly, M.D., is a meditation on work and a career in medicine. Yet, it transcends the story of one doctor, goes far beyond an "n of 1" anecdote and achieves its greatest success by telling the story of every doctor and the values that underlie medical practice.

The book is divided into three sections, titled "Now," "Then" and "Now." Both "Now" sections focus on two weeks where Reilly serves as ward attending on the Inpatient Internal Medicine service at Cornell's Presbyterian Hospital. Through Reilly's use of compelling stories and human drama, he holds tight to the foundational values of medicine, while computers, short stays and transient physician-patient relationships threaten to disrupt its practice. His father's phone call interrupts Reilly's work; his mother is ill and will need to go to their local hospital, reminding Reilly that he has returned to New York, in part because his aging parents have no primary care doctor, and he will need to coordinate their care.

"Then" ~ the second section ~ deals with Reilly's early career at Dartmouth, a section dominated by the story of longtime patients, Fred and Martha. Early one morning, he is summoned to their house. He finds Fred slumped in a chair, dead from a self-inflicted gunshot wound, and a distraught Martha. Through the lens of this relationship, we are treated to Reilly's view on many issues confronting medicine: end of life, medical errors and boundary issues in the physician-patient relationship, among them. We accompany Reilly as he wonders whether he contributed to Fred's demise.

"Now" ~ back to the wards; the same focus on patients by day, balanced by increasing demands of his parents' care by night. His father struggles and ultimately succumbs to disseminated bladder cancer; his mother struggles with dementia. While many roads in this book seem to lead to disability and death, Reilly makes it clear that the joy and satisfaction of medicine is not necessarily in the destination, but in accompanying each other in the journey.

David Hatem, M.D., is professor of Medicine and the co-director of Learning Communities Program at the University of Massachusetts Medical School. He can be reached atdavid.hatem@umassmemorial.org.

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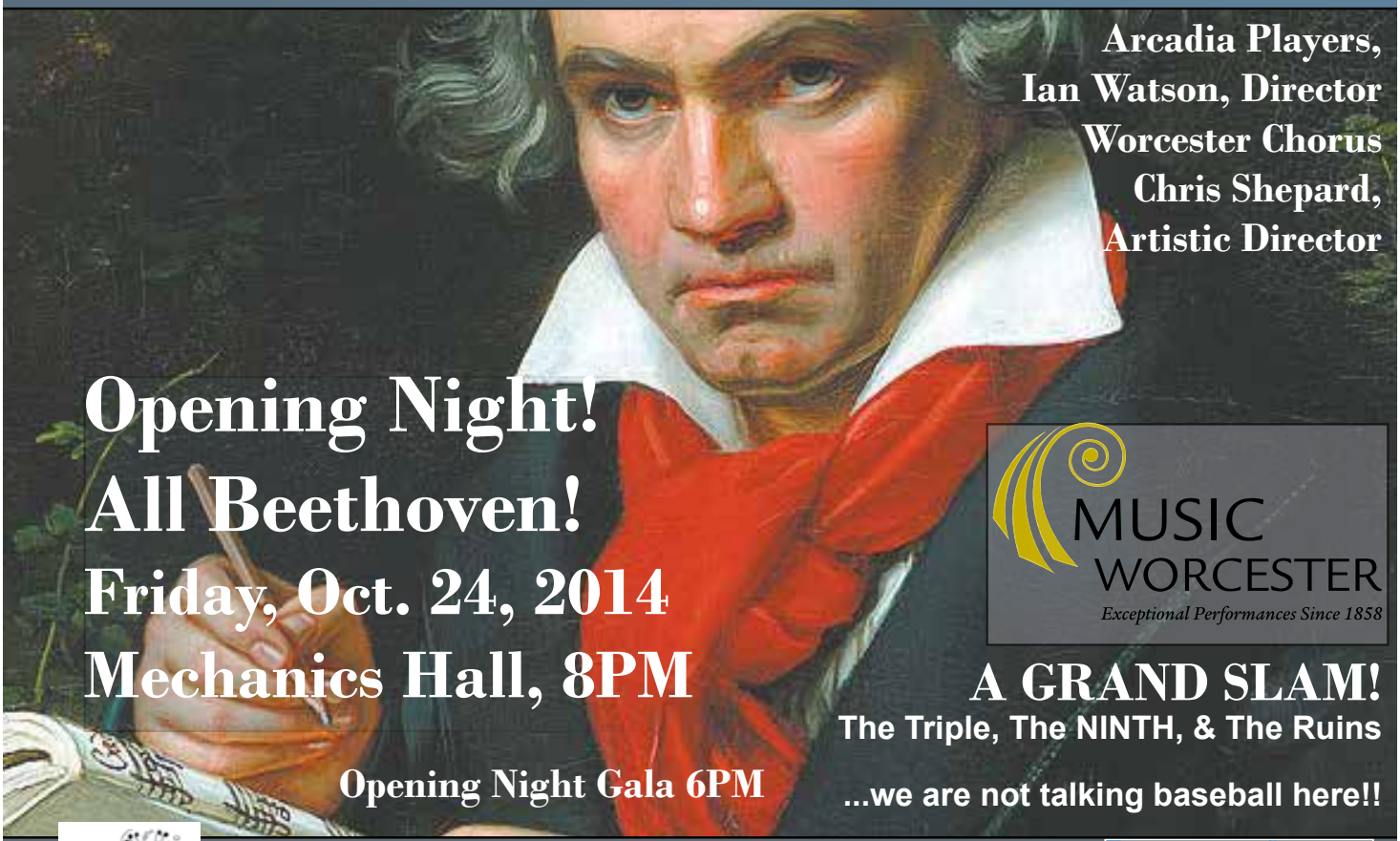

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Andrea Chenoweth, soprano; Emily Marvosh, alto; Stefan Reed, tenor; Woodrow Bynum, bass

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Worcester District Medical Society

Calendar of Events

2014

September 12 (Friday, 7:30 a.m., Beechwood Hotel)

23RD ANNUAL WOMEN IN MEDICINE BREAKFAST

"Covering the Middle East"

Speaker: N. Lynn Eckhert, MD, MPH, DrPH, director for academic programs, Partners HealthCare International; professor, family medicine and community health, University of Massachusetts Medical School; senior lecturer, Harvard Medical School; former interim dean, Lebanese American University School of Medicine

Cosponsored by Physicians Insurance Agency of Massachusetts (PIAM)

September 22 (Monday, 5:30 p.m., Beechwood Hotel)

FINANCIAL PLANNING SEMINAR

"Managing Student Debt"

Cosponsored by Physicians Financial Services

October 15 (Wednesday, 5:30 p.m., UMass Medical School Campus)

AUTHOR EVENT

"One Life/Many Deaths: A Surgeon's Stories"

Speaker: Brownell Wheeler, MD, founding chair of the Department of Surgery, the first chief of staff of the University of Massachusetts Medical Center and Harry M. Haidak Distinguished Professor of Surgery emeritus; founding chair of the Worcester District Medical Society's Committee to Improve End-of-Life Care and founding president of the Massachusetts Compassionate Care Coalition

October 29 (Wednesday, 5:30 p.m., Beechwood Hotel)

9TH ANNUAL LOUIS A. COTTLE LECTURE

"Risks and Benefits of Medical Marijuana"

Speakers: George Abraham, MD, moderator; James B. Broadhurst, MD; Alfred DeMaria, MD (invited); Eric J. Ruby, MD; William Ryder, Esq.

November 12 (Wednesday, 5:30 p.m., Beechwood Hotel)

FALL DISTRICT MEETING

The dinner meeting includes the A. Jane Fitzpatrick Community Service Award, the WDMS Career Achievement Award, and scholarship award presentations.

December 5 & 6 (Friday and Saturday, 9:00 a.m., MMS headquarters and Westin Hotel, Waltham)

2014 INTERIM MEETING AND MEETING OF THE MMS HOUSE OF DELEGATES

All WDMS members are invited to attend as guests and may submit a resolution to the Massachusetts Medical Society.

December 18 (Thursday, 5:30 p.m., Washburn Hall, Mechanics Hall)

A NIGHT AT THE MOVIES

The Doctor

Jack McKee, played by William Hurt, is a doctor with it all: he's successful, he's rich, and he has no problems.... until he is diagnosed with throat cancer. Now that he has seen medicine, hospitals, and doctors from a patient's perspective, he realizes that there is more to being a doctor than surgery and prescriptions.

Group discussion and holiday celebration will follow.

2015

February 11 (Wednesday, 5:30 pm, Beechwood Hotel)

219TH ANNUAL ORATION

"Art and Medicine"

Orator: Paul Steen, MD

Paul Steen was in the private practice of internal medicine in Southbridge and was a vice president of clinical development at McKesson Corporation until his retirement in 2005. Currently, he is a docent at Worcester Art Museum with an interest in art as applied to medical training.

February 20 (Friday, 7:00 p.m. reception; 8:00 p.m. program, Mechanics Hall)

BOSTON PHILHARMONIC ORCHESTRA, BENJAMIN ZANDER, CONDUCTOR

March 11 (Wednesday, 5:30 p.m., Beechwood Hotel)

WOMEN IN MEDICINE LEADERSHIP FORUM

Program to be determined

March 30

DOCTOR'S DAY

March 30 is National Doctors' Day, a day when patients, friends, family, and colleagues honor physicians and express their gratitude for physicians' continuing commitment to patients and exceptional medical care.

Sponsored by the Worcester District Medical Society Alliance

April 8 (Wednesday, 5:30 p.m., Beechwood Hotel)

ANNUAL BUSINESS MEETING

Meeting includes presentation of the 2015 Community Clinician of the Year Award

Speaker: Carol Ann Small

Carol Ann Small, founder and CEO of Laughter with a Lesson, is a nationally recognized motivational humorist and stress and work/life balance expert who imparts wisdom with a twist of real-life humor.

April/May 30 – 2 (Thursday and Saturday, 9:00 a.m., MMS headquarters, Waltham, and the Seaport Hotel and World Trade Center, Boston)

2015 MMS ANNUAL MEETING AND HOUSE OF DELEGATES

WDMS members are invited to attend as a guest and may submit a resolution to the Massachusetts Medical Society.

May (Wednesday, University of Massachusetts Medical School)

MEET THE AUTHOR SERIES

Date to be determined

Cosponsored by WDMS and Humanities in Medicine Committee of the Lamar Soutter Library at the University of Massachusetts Medical School

Elliott Reiner (1920-2013)

I first met Elliott Reiner, M.D., almost 40 years ago, when I was a Beth Israel Hospital (Boston) psychiatry resident doing a six-month rotation at Worcester State Hospital. At that time, the patients had recently vacated the Clock Tower complex, but the administrative offices (and the resident's on-call room!) remained in the Clock Tower building itself. Dr. Reiner was a supervisor of mine during this half-year venture into the world of public mental health, and he was a wealth of knowledge. I remember him as a quiet man, one who was there to help in a most unassuming way. He left the residents to find their own way. He trusted I'd have the good judgment to show up at his door if I needed to, and that if I wasn't there, he wasn't going to hear about some disaster the next day.

Dr. Reiner had impressive qualifications. He spent one year at Clark University before matriculating at the University of Alabama, graduating in 1942. He immediately moved on to Yale University, obtaining his M.D. degree in 1945. He interned at St. Elizabeth's Hospital in Washington, D.C., and did his residency while in the armed service at U.S. Naval Hospitals in Bethesda, Md. and Portsmouth, Va.

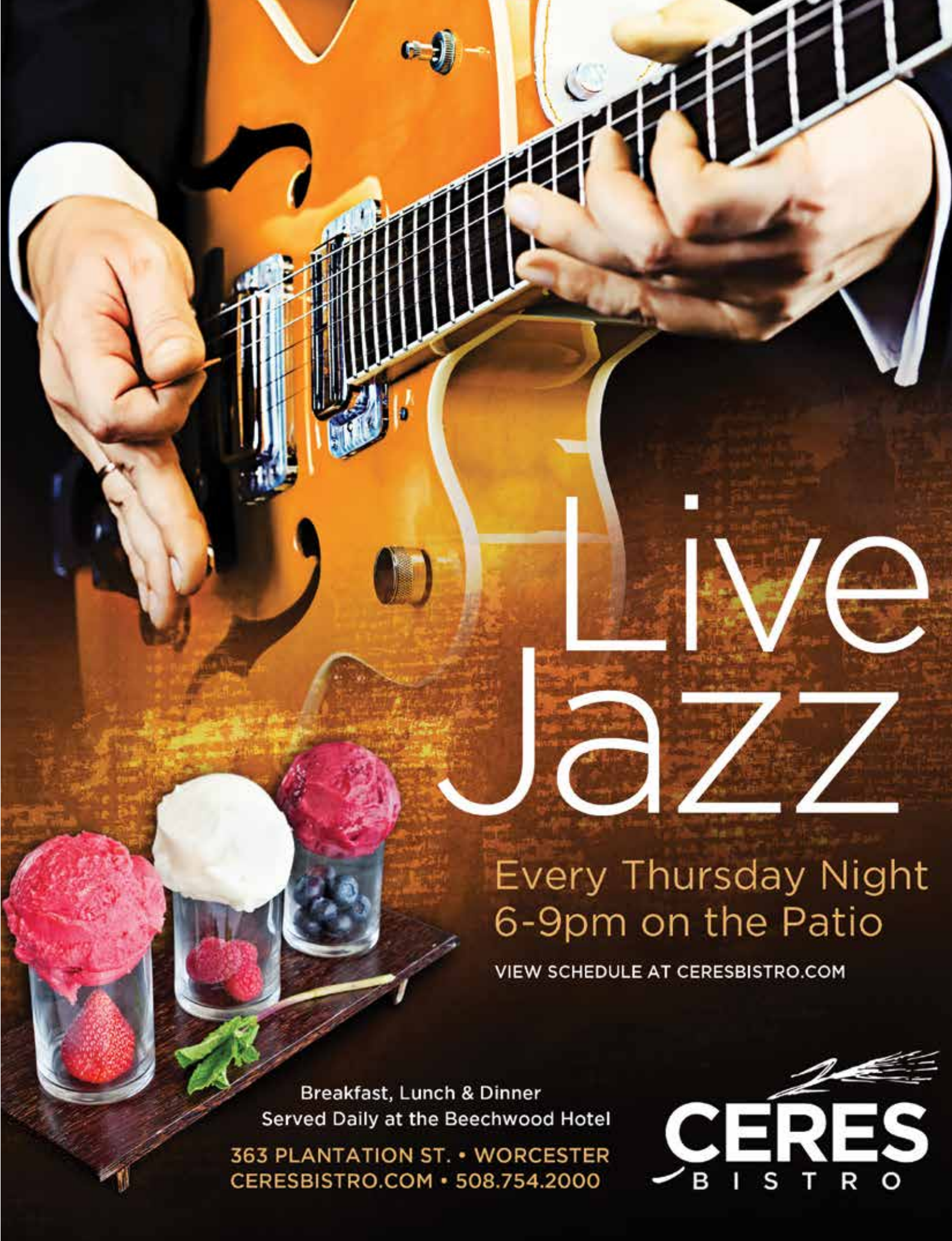
In 1948, Dr. Reiner returned to Worcester to join the staff of Worcester State Hospital. He became psychoanalytically trained, attending the Boston Psychoanalytic Institute.

At a time when good-quality public sector psychiatrists were not easy to come by, Dr. Reiner was all over Worcester County making important professional contributions. Dr. Reiner worked at Worcester City Hospital, Worcester Youth Guidance, Rutland Heights Hospital, Hahnemann Hospital, St. Vincent Hospital, Worcester Area Council of Churches, Memorial Hospital, Worcester Pastoral Counseling Center, WPI, Westside House Long-term Care, UMass Medical School and private practice in the city of Worcester. This list may give the impression Dr. Reiner was a peregrinating psychiatrist or a journeyman in Worcester County. But that was not the case at all. Many of his assignments he did contemporaneously, filling the needs of the county.

Dr. Reiner also had research interests. He wrote articles on topics that would seem to any current resident to be ancient history ~ lobotomy, insulin coma therapy ~ and on topics of our highest contemporary interest ~ employability of persons released from psychiatric hospitals.

Elliott Reiner, M.D., died April 10, 2013 at the age of 93.

Jeffrey Geller, M.D., M.P.H.
professor of Psychiatry at UMass Medical School.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