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## Peering into the Health Profession: Who's Watching?



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**Jane Lochrie, MD**

The American Medical Association defines medical peer review as "...the process by which a professional review body considers whether a practitioner's clinical privileges or membership in a professional society will be adversely affected by a physician's competence or professional conduct. The foremost objective of the medical peer review process is the promotion of the highest quality of medical care as well as patient safety." This issue of *Worcester Medicine* examines the peer review process for physicians, medical students and nurses.

In the first article, Dr. Sanchez describes the purpose and goals of the Physician Health Services (PHS), Inc., a corporation of the Massachusetts Medical Society, a confidential resource for physicians, residents and medical students experiencing health concerns including behavioral, mental health, or substance abuse issues and/or physical illness. PHS hosts a number of support group meeting for practitioners in recovery and for those seeking peer support.

Dr. Bessette's article describes the way in which a rigorous internal peer review process can promote quality improvement and patient safety. Optimal provider and patient outcomes occur when peer review programs align their goals with hospital Quality Improvement initiatives. He explains how peer review activities should identify substandard performance and provide and monitor remediation.

Medical students and other health care professional students are not immune to ill health. Dr. Ruth Ann Rizzi's article clarifies the importance of lifelong self-care beginning in medical/graduate school. This is especially important as students start their clinical rotations and can easily obtain informal consults and prescriptions from colleagues. The University of Massachusetts provides comprehensive student health and counseling services, making medical care easily accessible and hopefully preventing students from seeking curbside self-consults and informal interventions.

The final article is timely given the outbreak of Hepatitis C in the cardiac catheterization lab at Exeter Hospital, likely from an employee who used syringes to self-inject medication and then reused the syringes on patients. Nurses and nursing students have high stress jobs and easy access to medications, placing them at risk for substance abuse. Mr. Cody's article describes the signs and symptoms of impairment and the requirement of reporting a colleague whom he or she suspects is impaired.

Jane Lochrie, MD

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# President's Message

Michael Hirsh, MD



Michael Hirsh, MD

As we enter the fall season, I would like to share with you some reflections on the past year and some projections on the upcoming final year of my tenure with WDMS.

My overarching goal with my presidency was to continue to cultivate participation and membership amongst the younger generation of

Worcester physicians and fu-

ture physicians. We wanted to establish ourselves as the organized medicine vehicle that was relevant and responsive to the membership's needs. To that end, we repopulated many of our standing committees with student and resident members who made amazing contributions throughout the year. We held a special educational seminar in the fall about financial planning/advice for the young physician. Our Women in Medicine seminar this year, organized by Dr. Becky Spanagel, featured Dr. Marianne D. Felice speaking about techniques of mentoring male vs female mentees. Dr. George Abraham helped respond to new Board of Registration in Medicine requirements on opioid prescription with a Cottle lecture done in cooperation with the Mass. College of Pharmacy on just that topic that resulted in one of the best subscribed programs in memory. We revived a past feature of our spring meeting that allowed us to invite our guest speaker, Dr. Darshak Sanghavi, to tell us the fascinating evolution of work hour restrictions in medical education and prac-

tice. Dr. Jay Broadhurst continued his stellar leadership of both the Public Health Committee and our WDMS Delegation to the MMS House of Delegates Meetings. In so doing, he helped advance positions on Gag laws re: physician inquiry into gun ownership, oral health initiatives, medical marijuana and nasal Narcan. Dr. Dennis Dimitri continues his Chairmanship of the Legislative Committee during which he hosted a breakfast at which the WDMS was able to engage in a free-wheeling discussion of the current state legislative initiative on payment reform. Dr. Jane Lochrie took over the reins of the Editorial

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Board for Worcester Medicine from Dr. Paul Steen and continued to produce a wonderful edition of increasing quality every other month, each time featuring topics right out of the medical news headlines. Drs. Bruce Karlin, Jay Broadhurst, and Lynda Young work with Joyce at WCCA-TV Channel 13 to produce our informative "Health Matters" TV show, with great topics and guests that add to relevancy of WDMS; the programming is now available at our website, [www.wdms.org](http://www.wdms.org)

With a 218 year history, it is vital that the organization continue to celebrate our rich past. Our orator this year, Dr. Charles Birbara, regales the assemble crowd at the Beechwood Hotel with rich memories of the beginning of the medical school era in Worcester and on the beginning of a storied track record of successful clinical trials.

The Worcester Medical Library developed a Spoken History project in partnership with the Society. Medical students interviewed 73 senior physicians whose practices spanned an era of tremendous change. Interviews were conducted from 1995-2002. A new feature article, "Spoken History," featuring summaries of this wonderful collection, are now being shared with the readership of Worcester Medicine. Many thanks to members of the Editorial Board and others who have helped with this project.


My personal WDMS favorite historical insight was taught to attendees of a special Civil War Remembrance event hosted by WDMS in May at Mechanics Hall. There, Dr. Peter Viles, one of the founding members of the Dept. of Pediatrics at the UMass Medical School, traced the activities of the 15th Mass. Union Army Regiment that had been assembled in Worcester and participated in many battles right up to the surrender of Lee's Army of Northern Virginia at Appomattox. The incredibly scholarly talk celebrating the 150th anniversary of the Civil War and Worcester's involvement in the effort, featured a fascinating tour of Mechanics Hall, one of the last of the pre-Civil War concert venues still around.

Lastly, a shout out once again to Joyce Cariglia, her wonderful administrative assistant Melissa Boucher, and our dauntless treasurer Robert Lebow for keeping yours truly and our whole organization on track. I would also like to acknowledge Miriam Bradley, President of our Alliance

organization, and its members for their continued support for a healthier Worcester community and a more collegial medical culture in our city.

Our trajectory for this next year looks very promising. This only happens because of the depth and energy of our membership and the vision that they generate. Thanks for the honor and privilege of serving another year as your president.

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# Taking Care of Ourselves to Better Care for Our Patients

Luis T. Sanchez, MD



**Luis T. Sanchez, MD**

Physicians are often reluctant to seek help. Our schedules are too busy, we don't want to contact or find a PCP, or we are reluctant to share our own history due to embarrassment or fear of exposure. We can become our own expert of what ails us. Or the inability to recognize the symptoms or the denial of substance abuse can lead us to become isolated and fearful of discovery. Even those closest to us might not recognize a develop-

ing problem because of our secrecy and unwillingness to talk about ourselves.

Our value to society and the medical world is clear. Physicians possess the medical knowledge and skill that others do not. We are expected to be the medical leader and it is assumed that we are medically and mentally fit to be such. But because this is at times not true, state physician health programs (PHP) are available to the physicians in the state to provide assistance and support.

Physician Health Services, Inc. (PHS) is one such program and is available to all Massachusetts physicians, residents, and medical students. PHS, a corporation of the Massachusetts Medical Society, is a confidential resource for those experiencing health concerns, including behavioral or mental health issues, substance use disorders, and/or physical illness. PHS provides a safe environment for physicians to talk to their peers about the stress and demands of modern medical practice. Assessments are designed to identify the health concerns impacting the affected individual's life and provide recommendations and resources to assist that person. Anyone is welcome and encouraged to contact PHS on his or her own behalf. In addition, PHS receives referrals from colleagues, family members, friends, hospitals, medical schools, and the Board of Registration in Medicine.

When someone contacts PHS, the director and associate directors assess the situation and guide the individual through the appropriate channels. Participation with PHS is voluntary and confidential. PHS will strongly urge a physician who is ill to get help, and although PHS does not provide direct treatment, we will suggest specific resource and treatment options. PHS hosts a number of support group meetings for physicians and medical students in recovery, as well as for those who are seeking peer support.

When PHS determines that a physician has a substance use disorder, is at risk for impairment, or has a behavioral health concern that warrants monitoring, the physician is encouraged to enter into a PHS monitoring contract. The monitoring contract specifies a course of treatment and documents the physician's compliance with the treatment plan. The standard contract requires individual therapy, group support meetings, regular meetings with a designated PHS associate director, random urine drug tests (if indicated), and regular interaction with a monitor and chief of service in the workplace who agree to help document the physician's compliance.

Recent peer reviewed studies attest to the high success rates with physicians in state physician health programs such as PHS.<sup>1</sup> With either the restoration to good health or the prevention of impairment, the PHP involvement aims at patient and public safety through physician well-being. This risk management aspect of PHPs has led to the support of liability insurance carriers in funding these non profit entities. PHS outcomes are more successful than outcomes for general public suggesting an optimal chance toward recovery for those physicians and medical students who seek out help. PHS has published a 75% success rate for both the substance use and the behavioral contracts of those physicians and medical students who have been monitored.

Physicians are susceptible to all the illness and disorders that our patients develop. The rigors and stresses of being a doctor



contribute to our unwillingness to provide self care, and can enhance our own denial of early illness, including depressive symptoms or the onset of drinking too much, self medicating with prescription medications, or behavior problems.

The stress of medical practice, if not recognized and dealt with, can lead to practicing problems impeding patient safety and good patient care. Potential stressors are manifold, including financial, legal, familial, medical, mental or addictive. The threat of a malpractice suit and the suit itself are often extraordinary stressful, and in the face of it, the physician is expected to carry on the daily medical practice.

PHS encourages early intervention and involvement prior to the physician's patient care being affected. Physician health programs have protocols in conjunction with the licensing board to divert the physician from disciplinary investigation if there are no violations of law or no patient harm and confirmation of successful participation. PHS does not clinically treat the physician but has referral access to well-established professional treatment programs.

The work of PHS and the state PHPs can easily be seen as significantly contributing to the risk management of medical practice. Healthy physicians are more apt to lead to healthy patients in the practice.<sup>2</sup> Physicians who have allowed themselves to become self aware of their style of practice and their vulnerabilities, have their medical problems diagnosed by their own providers, and have benefited from treatment are more likely to be empathic, and have developed communication skills which benefit the patient/doctor interaction. The academic literature is beginning to recognize these connections as physician health asserts itself as a priority in medical practice. Recent articles attest to the importance of highlighting the health of physicians and are included in the bibliography.<sup>3</sup> PHPs are also becoming more cognizant of systems of care as being problematic not only to physician health but also to the health of other medical professionals and of the hospital or medical practice organization. New Joint Commission standards as of January 2009<sup>4</sup> outline the importance of recognizing and correcting disruptive behaviors and conflict in the workplace; both are seen as important for quality care and patient safety.

The importance of health of the physician is becoming fundamental to the practice of medicine. Practicing healthy habits, being a

team player, communicating well, and enjoying oneself in so doing, are goals to be reached by all doctors. The state physician health program is available to support and assist the physician in attaining these goals.

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Luis T. Sanchez, MD is Director, Physician Health Services, Inc.



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# “Physician Peer Review = Quality and Safety”

Robert Bessette, MD

This article will, I hope, compliment the theme and the goals of the current WDMS publication. Our profession must, in the current legal and remunerative atmosphere, demonstrate an effective policing program. These programs should additionally promote quality care and patient safety. A vigorous internal medical staff peer review program has emerged as possibly the most effective method to achieve these goals. Let me define Peer Review simply as a process whereby physicians evaluate each other's performance with a goal of improving quality and safety. These activities also reveal system issues to be corrected and, ultimately, the results should enhance overall improvement of the physician as well as the entire staff.

Current Peer Review programs aligned with hospital QI initiatives appear to be more capable of achieving these goals than previously employed outdated QA models that did not influence either goal.

Peer Review has been practiced in some form since ancient Greece.<sup>1</sup> A variety of peer review activities have occurred over time with QA based programs prevalent for many years.

Every hospital has bylaws and staff regulations governing peer review. However, variability in the process, the scope of the activity, governance, and commitment of each program has been the norm. There is a paucity of data reflecting effectiveness of programs relative to achieving quality and safety goals of peer review processes.<sup>2</sup>

A review by Edwards, 2011 demonstrated that despite differences between programs, improvements in quality and safety could be achieved if structured active peer review activities were supported by staff and administration.<sup>3</sup>

Allow me to put forth some thoughts regarding peer review parameters that would prove most effective.<sup>4</sup> I will also review some of the challenges that would be encountered. Presence of a medical staff and administration proactive culture rooted

in the QI rather than the QA structure is paramount. The former would foster an atmosphere recognizing substandard performance ~ the rare flagrant occurrences as well as the more frequent equivocal deviations from clinical guidelines. This milieu will lend itself to more accurate performance measurement feedback and overall performance improvements. This stands in stark contrast to the error finding and punishment philosophy of QA methodology.

Peer review activities should not address competence, the purview of credentialing activities. On the other hand, peer review should identify individual substandard performance as well as monitor appropriate constructive remedial actions. If monitoring has demonstrated no attempted improvement, the peer review committee has an obligation to recommend further action in compliance with staff structures. System issues that may have influenced substandard performance may be addressed and attempted resolution of the problems through medical staff procedures can be pursued.

Peer Review activities, deliberations, and recommendations should be in synchrony with other hospital functions, i.e. utilization. Performance measurement should be set only if the hospital can support the measures with available utilization and ancillary support.

Performance parameters should be established and measured over time. Only with time will comparative assessment of individual and group performance be possible. Demonstration and disclosure of improved performance will foster a confidence in the profession's commitment to quality and safety. Staff bylaws and regulations must clearly define the process or the procedure by which clinical events are brought to review. These processes may vary amongst institutions, and these variations will be determined by the needs and objectives of the organization. The format chosen must be implemented uniformly, without bias, following clear delineation and understanding by all concerned. Adherence to these stipulations may be challenging in



some instances. Small medical staffs or staffs with few members of a specialty might find it difficult to engage opinions from another practitioner with no economic or other conflict with the physician under review. This may be difficult to accomplish but our professional integrity and commitment must prevail. External review, often times at considerable expense, may be necessary.

Equally important are the processes by which cases are reviewed, creating universal understanding of decision making and appeals processes. All decisions regarding initial decision to review, deliberations, and decisions by the Peer Review Committee and the appeals should be based on evidence based guidelines, local practice standards, and the opinions of the physician or physicians being reviewed. This must be part of the process. With mixed views on a decision, minority views must be expressed in the official report. Decisions cannot be influenced by cost or contractual considerations.

Currently, confidentiality and non-discoverable status have been essential to any perceived peer review success. Could disclosure of remedial action taken, demonstration of improvement over time after action taken be useful in demonstrating to the public as well as to regulatory bodies and insurers that we, as professionals, are serious about the issues? Could confidentiality and immunity from discovery remain supporting the current system? Our professionalism mandates our best effort in reviewing substandard care at all levels and instituting remedial action in monitoring the results. We also possess a mandate not only to defend ourselves but to disseminate our commitment for goals of safety and quality to our patients. Can an enhancement of our current Peer Review activities and publication of actions taken in pursuit of quality and safety be reconciled with the necessary confidentiality and non discoverable aspect of Peer Review?

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# Helping Students in the Health Profession Reduce Isolation

Ruth Ann Rizzi, MD



Ruth Ann Rizzi, MD

Recently, Physician Health Services (PHS) gave a presentation to the Board of Registration in Medicine (BRM) which outlined the monitoring provided to ill and impaired physicians and medical students in the state of Massachusetts. One of the primary issues raised by the BRM was the question as to what was being done specifically for the medical students so that they might not needlessly arrive one day before the BRM for licensure review.

Why the BRM might think to delve more deeply into this issue is likely due to two important confounding facts: not only do many medical professionals delay or avoid personal healthcare<sup>1</sup>, they also tend to avoid the responsibility of guiding reluctant colleagues into treatment and/or monitoring<sup>2</sup>.

The tendency towards these self-defeating behaviors begins in education and training<sup>3,4</sup>. Isolation, a difficult cause and effect of a number of illnesses leading to self-harm, becomes a burgeoning problem for students entering the health professions. Nursing and medical students begin to bear clinical burdens, such as patient confidentiality, which can foster social isolation.<sup>5</sup> Graduate students in the biomedical sciences enter a highly competitive world where sharing with a colleague may not be without some risk. Health professions students across the board begin to be held to a very high standard and, without adequate support, this can lead them to be more critical of themselves.<sup>6</sup> Fears of stigma can lead to isolation from academic supports due to fears of potential jeopardy if a supervisor were to discover a student's personal health issue; these fears tend to be strongest for problems centering around drugs/alcohol.<sup>7</sup>

Yet, there is institutional support for the idea that the groundwork for good, lifelong self-care for medical professionals begins early on in medical/graduate school. Data indicates that medical schools are heeding the call and "...serve as the principal providers of care for most [medical] students."<sup>8</sup> They are uniquely suited to provide students with convenient and accessible services with cost reduced by economies of scale without losing sight of the needs for confidentiality.<sup>9</sup>

This is especially important for medical students, because the advent of their clinical training in the 3<sup>rd</sup> year of medical school coincides with the increase in care seeking through informal consultation with colleagues, half of whom (residents and physicians) write prescriptions for themselves, and often themselves seek informal treatment from colleagues.<sup>10</sup> Having strong, formal, school-based programs for treatment serves as a bulwark against such self-defeating care. Locally, the University of Massachusetts Medical School has a very comprehensive student health services program and very active student counseling services. These programs serve the nursing, graduate, and medical students of the campus, and utilization rates reflect high penetrance. For example, our statistics show that amongst the 2012 graduating medical school class, 46% of the students had sought out the student counseling services sometime during their medical school enrollment.

The Federation of State Physician Health Programs' public policy statement on physician illness emphasizes early identification and treatment of illness.<sup>11</sup> The various states' Physician Health Programs (PHPs) have begun to extend their services to medical students, and in some states to nursing, dental, and graduate students. These programs can often relieve the schools of the burden of monitoring students' substance abuse/mental health disorders, allowing both school and student to focus on academic issues. In addition to extramural privacy, PHPs often



work very closely with their respective states' medical boards, smoothing the path to initial licensure for monitored students. Here in Massachusetts, PHS runs support and 12-step groups limited to health professionals/ students; these groups are free of charge and are available regardless of involvement with monitoring contracts.

For those students less in need of a professions-based group, one promising area of help is the peer-assistance model, which is most active on undergraduate college campuses. The primary example of this model is Active Minds, whose website emphasizes their role in student-run mental health awareness, education, and advocacy on campuses. As mental illness loses its stigma, the receptiveness to such student-based campus resources will likely increase on medical school campuses. Additionally, The American Foundation for Suicide Prevention supports a web-based tool for anonymous entry into communication with school-based counseling services. A pilot of this program has recently been extended into a few medical school campuses.

Finally, as noted in JAMA recently, "Self-regulation is central to the ideology of medical professionalism...yet has become increasingly complex...contemporary methods of self-regulation have been created by the profession in ...recognition that sole reliance on individual physicians...would not be enough to meet shared obligations for quality assurance and patient safety."<sup>12</sup> We hope that by beginning these efforts at the student level, health professionals will be empowered to maintain optimal care of themselves just as they begin the endeavor to provide optimal care for their patients.

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# Nursing's Approach to Addiction

Shawn Cody, MSN/MBA, RN



**Shawn Cody, MSN/  
MBA, RN**

In 2010, over 20 million Americans age 18 or older had a diagnosis of substance or alcohol dependence or abuse (Substance Abuse and Mental Health Administration, 2012). That figure, nearly 9% of the general population, includes an unknown number of health care staff and students (Monroe, Vandoren, Smith, Cole & Kenage, 2011). Among nurses, emergency, critical care, and anesthesia nurses have the highest prevalence of substance abuse (Trinkoff

& Storr, 1998). The Massachusetts Department of Public Health (2012) cites difficult working conditions, increasing stress, and ~ most importantly ~ daily access to medications as contributing factors.

## Ethics and Policy

Nurse substance or alcohol dependence and abuse, or impairment, can endanger patients (McNelis et al., 2012). Nurses have ethical and legal responsibilities to protect patients and the nursing profession from the harms related to nurse impairment. The American Nurses Association (ANA), state boards of nursing, and organizations such as hospitals and nursing homes guide the prevention, detection, reporting, and treatment of nurse impairment.

The ANA Code of Ethics (2001) (the Code) requires nurses to be vigilant about the possibility of a colleague's impaired practice. Nurses have a duty to take action if they suspect a colleague is impaired, to protect patient safety, and to ensure that the impaired nurse receives assistance. The Code intends advocacy for patients and nurses, emphasizing prompt, safe reporting and compassion, rather than punishment, toward nurses struggling with impairment. The Code refers concerned nurses

to local reporting processes (if applicable), such as through supervisors. Ultimately, state boards of nursing have the power to revoke an impaired nurse's license to practice for violation of the state's nurse practice act.

## Detecting Impairment

All nurses should be aware of the signs and symptoms of impairment. Overt signs may include the smell of alcohol on a nurse's breath, unexplained disappearance during shifts, or sleeping on the job. More commonly the signs are subtle and include gradual change in practice, sloppy documentation, tardiness or increased absenteeism, or mood swings.

When a nurse brings forward suspicion of a colleague's impairment, nursing administration works closely with pharmacy, human resources, and state agencies to investigate. If the complaint is deemed serious enough, the nurse is put on a paid leave while the investigation takes place.

For example, when there is concern that a nurse is abusing medicines intended for patients, the investigation includes tracing the nurse's handling of medications. Most large health care facilities are equipped with electronic medication dispensing systems that allow investigators to generate usage reports. These reports can efficiently collate data of what may be thousands of transactions to display usage patterns or other potential red flags that may indicate diversion of medication from the patient to the impaired nurse. With these reports as a starting place, the investigators review related patient records thoroughly, often on a transaction by transaction basis. This time-consuming activity includes review of the medication order, frequency, amount removed from the dispensing system, amount given to the patient, the reason the medicine was needed (such as the patient complained of pain), and the related documentation. Once the record review is complete, the next step is to interview the nurse involved. The interview needs to be methodi-

cal as each transaction in question is examined with questions including “How do you explain this transaction?” or “Under what circumstances would you administer this medication and not document it?” This allows the nurse to speak to possible discrepancies. The interview also includes discussion of any noted behavior changes, if applicable, and informs the nurse that colleagues have reported concerns. This stage is extremely delicate as the nurse is hearing concerns from peers as well as management. It is important that the identity of staff who come forward be protected if possible. They need to feel safe in bringing concerns about impairment forward without fear of repercussions.

The outcome of the interview and record review is careful evaluation of the medication administration data, and the nurse’s response, to judge whether he or she is reasonable. This judgment typically involves supervisory and administrative staff, such as the nurse manager, nurse administrator, pharmacy leadership, and human resources. At this point, depending on the findings, the facts of the case are reported to the state board of nursing.

Oftentimes when impaired nurses are confronted with evidence from this type of review, they voluntarily resign their positions and enter the rehabilitation program offered through the state board of registration. In the investigation process, the ultimate goals of the nurse’s employing institution are to protect patients from harm and assist the affected nurse in getting help to return to healthy living.

### Treatment of Impaired Nurses

Since the 1980s, over 40 of the 50 state boards that oversee professional nursing licensure in the US have had in place some form of rehabilitation program (Munroe et al., 2011). While programs differ somewhat in detail, all are grounded in a treatment versus punishment perspective. In Massachusetts, the Substance Abuse Rehabilitation Program (SARP) functions in this capacity. The goal of the five-year program is to assist nurses who have issues with alcohol or other drugs in returning to practice as a voluntary alternative to criminal prosecution and/or forfeiting their nursing license. The program includes rigorous requirements of the participants, including counseling, limitation about where they can work, limited or no access to medications, random toxicology screenings, and mandatory attendance at Alcoholics or Narcotics Anonymous meetings.

The duty to address impaired practice is the responsibility of all nurses. For more information, visit the *Massachusetts Nurses Association’s Guidebook to Impaired Practice* (2011) at [www.massnurses.org/nursing-resources/nursing-practice/impaired-](http://www.massnurses.org/nursing-resources/nursing-practice/impaired-)

[www.mass.gov/eohhs/provider/licensing/occupation/nursing/](http://www.mass.gov/eohhs/provider/licensing/occupation/nursing/). For information on the Massachusetts SARP, visit [www.mass.gov/eohhs/provider/licensing/occupational/nursing/sarp](http://www.mass.gov/eohhs/provider/licensing/occupational/nursing/sarp).

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# How many licks does it take to get into the Pediatric Intensive Care Unit? The hazards of accidental ingestion of buprenorphine/naloxone (Suboxone) in children

Scott T. Bateman, MD



**Scott T. Bateman, MD**

“We have another toddler with a Suboxone ingestion needing the PICU” is a call I receive from our emergency room frequently on service in the Pediatric Intensive Care Unit at UMass Memorial Children’s Medical Center. Suboxone contains two drugs: 1) the partial mu opioid receptor agonist buprenorphine and 2) naloxone, an opioid antagonist. The ratio is 4:1 buprenorphine to naloxone. It is used for the treat-

ment of opioid dependence and has an excellent success rate and safety profile in adults. In children who are opioid naive, the buprenorphine activity can lead to significant opioid toxicity. The patients coming to the PICU have various degrees of this toxicity on arrival, and all require close management for respiratory depression. A significant number have been treated with repeated doses of IV naloxone, the antidote. We started noticing this trend back in 2009 and subsequently I co-authored a paper on the incidence and complications of Suboxone ingestions in the PICU. We found that for all ingestions in our toddler age children, Suboxone was the most common, accounting for 33% of all accidental ingestions. We also reported that the drugs were all prescribed to a child’s caregiver in the household. Since that paper was published, our PICU has seen a steady and ongoing influx of patients with Suboxone overdoses. It appears that prescription uses of Suboxone have broadened and thus more of this drug is available. Children are drawn to this little orange pill because it looks and feels like an M&M. It is

imprinted with a sword logo on one side. Because the drug is absorbed sub-lingually (enters the body by being absorbed by the mucous membranes in the mouth), all the child has to do is place the pill in his/her mouth to begin getting the effects of the buprenorphine. Licking the pill will also provide systemic absorption of the buprenorphine. The smaller the child, the larger the dose per lick for his or her body size. Therefore, it doesn’t take many licks (or time in the mouth) before a child could start showing signs of opioid toxicity with sleepiness and lethargy. Almost all other types of pills require the child to swallow them to get the toxicity.

My understanding from my adult colleagues is that there is a huge epidemic of prescribed opioid abuse in this area and that Suboxone is a big part of preventing further abuse and even death. This drug has had a significantly positive impact on these patients, helping to decrease HIV transmission, opioid overdose, and even criminal activity.<sup>2</sup> However, there needs to be greater awareness by both patients and providers regarding the potential dangers of accidental ingestion in order to protect the children. Efforts are underway on a state level to highlight the risks of Suboxone and children. A pamphlet has been prepared: <http://massclearinghouse.ehs.state.ma.us/protecting-others-and-protecting-treatment.html>. Single dose packaging is available for the medication, but it is unfortunately not covered by Medicaid. New preparations of the drug, a dissolvable film, may be more child-proof, but also may be more dangerous if found by a child. Discussing the risks to children is part of ongoing physician prescription training for this drug and contracts with patients about safe handling of the drug are required.

The risk of accidental ingestion of Suboxone is known and being addressed in different ways, but unfortunately the incidence of PICU hospitalization of children with Suboxone intoxication has been on the rise over the past 2 years. The families of these children explain, “One pill was left in the car,” or “Grandmother was over with her pills,” or “One must have fallen on the floor,” or “We didn’t realize that it was out,” or remarkably, “I gave it to my child because I thought it was candy.” It is frustrating to see how easy it is for children to get their hands on this drug. The kids are quickly attracted to this candy-like medication and this potent drug affects their small bodies very quickly. I am urging all who use or prescribe this drug to make extra efforts to follow up on its safe storage and am also urging ongoing home safety checks and, if possible, single dose packaging. With more awareness and emphasis on the dangers of Suboxone to children, we can make strides in licking this problem.

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# Massachusetts Medical Society House of Delegates

## Resolution 211

### Child Safety, MassHealth and Suboxone

Resolution Sponsor: James Broadhurst, MD

At its annual meeting on May 19, 2012, the House of Delegates (HOD) of the Massachusetts Medical Society (MMS) adopted the following policy statement:

That the Massachusetts Medical Society advocate to health insurers that the presence of a child in the household be cause to cover a child-proof or tamper-proof version of a prescribed drug where available.

I had submitted a resolution for consideration by the HOD with specific reference to buprenorphine/naloxone, an opiate agonist/antagonist used to protect patients from opiate withdrawal as part of their treatment for opiate dependence. This medication was originally formulated as a pink pill administered sublingually. I became aware that this was a particular hazard to children. In the fall of 2010, an alternative formulation consisting of a remarkably child resistant individual foil wrapped sublingual film became available. Many of the patients I serve with opiate dependence are covered by MassHealth, yet the film preparation is not covered. When my individual efforts to have the film preparation put on the formulary were unsuccessful and I became aware of Dr. Bateman’s experience as a Pediatric Intensivist (see adjacent point of view), I submitted the resolution to the MMS HOD. The reference committee wisely recommended that the HOD adopt policy focusing on the general principle rather than this specific example. I remain hopeful that MassHealth will change its formulary to cover the film preparation to reduce this now increasingly predictable unintended toxic exposure and enhance child safety.

James B. Broadhurst, MD, MHA

# Physicians Can Make an Impact

Michael Hirsh, MD

I had a very strange week filled with the stark contrast of experiences that make a career in medicine so unique. I am being shadowed this semester by a Holy Cross senior who visits me 2-3 times a week to shadow me in the OR, in office hours, during trauma evaluations in the Emergency Department, and during ward rounds. I enjoy the exchanges we have because so often these college students who are still a little bit unsure about their career direction ask you the tough questions that really make you take a step back and reevaluate what you are doing.

After seeing surgeries on Tuesday, my intern came to see patients during my office hours on Wednesday. Fortunately, a number of the postoperative cases had gone well and the parents and patients seemed happy and grateful. On the other hand, one parent was upset that I did not feel surgery was indicated for her child.

My intern asked if I frequently found patients or parents who were not in agreement with my plan. I answered that this was not a frequent occurrence but that it was part of the territory of living in an age when parents of patients or patients themselves get much of their information off the internet and frequently trust that more than they do the physician. I could tell by her reaction she thought the parent had come off as argumentative and unappreciative.

Then Saturday came. Amidst all the activity of the week, a dear friend of ours lost her husband to a long-standing battle with cancer. The funeral was Saturday and I was able to attend. There I witnessed our friend deliver an incredibly moving eulogy for her dear departed husband. What made it especially impactful was her description of her husband's last lucid days.

He recognized one morning after awakening that the end was near. He told his wife he would be crossing over to the other side soon. He summarily called all of his loved ones: his moth-

er, brothers, nephews and nieces. He essentially dictated to his wife what he wanted her to say in her eulogy.

But before succumbing to semi consciousness, he told his wife he needed her help to get in touch with his oncologist. He first spoke to office secretaries and nurses and, after thanking them for their many kindnesses, he received a promise that the physician would be reached and would call back.

When the physician did indeed return the call, what he heard might have surprised him. His patient told him that he wanted to thank him for extending his life almost five years and for treating him with respect, dignity and skill. The physician thanked him profusely for calling him in this way and said he only wished the conversation were occurring 30 years from now. With that, our friend's husband hung up the phone and within a week went to hospice care and then succumbed to his illness.

Sitting there amongst the mourners, I thought to myself about what an incredible gift this oncologist had been given; it wasn't just the call from a dying patient, but the opportunity to try to make a positive difference in such a patient's life. This is part of the great reward of medicine that we sometimes (i.e. I sometimes) forget. In a week in which my intern questioned whether patients appreciate the efforts of their physicians, I received guidance from a departed friend.

The message I will convey to my Holy Cross intern next week is that physicians do make a difference, and that the only way to continue to reap the great reward of a phone call like the one this oncologist received is to keep right on practicing; the impact we make upon the "creatures of pain" we encounter along the way can not always be measured in the short-term. But neither can anything meaningful in life.





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# Elbow-Deep in The Sausage:

## a Look Inside the House Quality Improvement and Cost Reduction Act of 2012

Peter Martin, Esq.



**Peter Martin, Esq.**

“Act Two” of Massachusetts health care reform, the attempt to rein in health care cost increases, takes one form in a bill recently introduced in the Massachusetts House of Representatives. Industry representatives are already lining up on both sides of the major policy positions in the bill, including the so-called “luxury tax” and “smart tiering” provisions. These positions will be extensively debated in the coming months, together

with other policy approaches found in a Senate bill.

Rather than being presented with just the differences between the two approaches, the reader may instead be interested to learn what else lurks within the House bill’s 96-page length. It turns out there are quite a few items in the bill that may or may not have a direct effect on health care cost containment. Here are just a few:

### Physician Organizations

This is a new subject of regulation ~ a group of at least ten physicians contracting as a single entity, but not including hospitals and clinics that already employ physicians. These organizations are to be certified by the Department of Public Health. Such organizations accepting alternative payments must create an internal patient appeals process; those accepting global payments must create an “external second opinion” process. It is unclear what problem is solved by certification of larger physician groups, in addition to individual physician licensure, and what such certification has to do with health care cost reduction.

### Nurse Mandatory Overtime

This provision prohibits a hospital from requiring a nurse to

work mandatory overtime unless in emergencies where patient safety requires it and there is no reasonable alternative. Public hearings will determine what constitutes an “emergency situation” and regulations are to be issued in early 2013, with the inevitable sanction of administrative fines for violating regulations beginning in 2014. In addition, the provision states that a nurse may not work 16 consecutive hours in a 24-hour period without at least an eight-hour break.

### Accountable Care Organization Licensure

This provision creates a state-level regulatory scheme separate from the ACO provisions created as part of the Medicare Shared Savings Program. The new Division of Health Care Cost and Quality (DHCCQ) will license ACOs and will enforce a wide scope of requirements. Unlike ACOs participating in Medicare, which participate in fee-for-service revenue but also may obtain payments for meeting savings and quality performance standards, under the Massachusetts scheme, ACOs are to be paid exclusively by an alternative payment methodology such as global payments, bundled payments, or shared savings payments. ACOs are to provide a minimum level of services determined by regulation, have a “transparent governing process,” and may not have more than 400,000 covered lives without a waiver from the Attorney General. They must meet certain quality and other measures enforceable by fines ~ a dollar a day per member for failure to meet the quality standards, and \$100 per day for failing to report the quality measures or certain financial data.

### Patient-Centered Medical Homes

By 2013, new standards of certification of patient-centered medical homes are to be developed by DHCCQ, which will be applicable to primary, behavioral and specialty care providers. All such providers are required to participate in a patient-centered medical home learning raining cooperative. A payment regimen will be developed by 2013 which may include payments based on care complexity, care coordination payments, and shared savings, all of which are to be in addition to fee-for-



service or global payments for services.

#### Changes in the Determination of Need Program

The bill proposes a uniform \$10 million expenditure threshold for inpatient and outpatient projects subject to DON approval, instead of the existing \$7.5 million (inpatient) and \$25 million (outpatient) thresholds. It also limits specific lists of innovative services and new technology that are subject to DON approval and replaces those definitions with a generic definition giving the DPH the ability to define such services and technologies based on quality, access or cost. However, the provision does add "interventional radiology units" as a new category of new technology subject to DON review.

#### Physician Assistants

A new law entitled "Consumer Choice of Physician Assistant Services" is created by the House bill that requires insurers to recognize PAs as participating providers and allow insureds to select a PA as his/her primary care provider. Elsewhere in the bill, the requirement that a physician supervise no more than four PAs has been eliminated, as has the requirement that a prescription written by a PA include the name of the supervising physician.

There are a great many other provisions in this House bill that seek to directly impact health care costs, such as a variety of ways in which providers and payer are to make their costs and charges more "transparent" to consumers. Others, such as a uniform physician credentialing application, may be beneficial in general but may have a less significant impact. It is to be anticipated that any legislative attempt to rein in costs of a large and varied industry will include a wide range of attempts to get at the problem. What is harder to predict is what will be the net effect of this miscellany of proposals in the real world.

*Peter J. Martin, Esquire, is a partner in the Worcester office of Bowditch & Dewey, LLP, whose practice concentrates on health care and non-profit law.*



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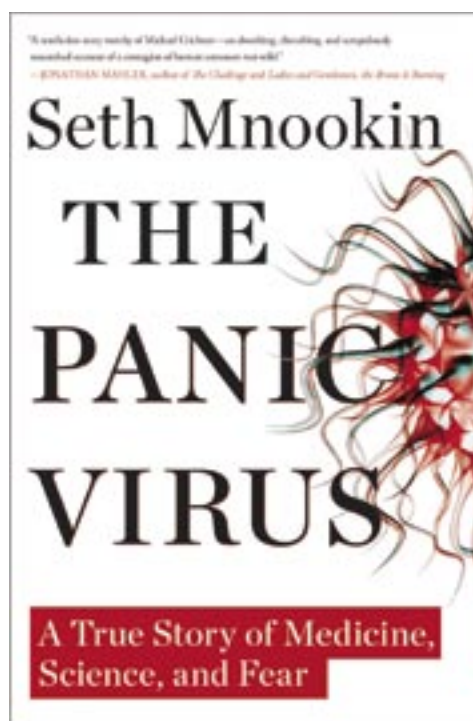
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# Seth Mnookin's *The Panic Virus*

Alan Haris, MD

In this book, Seth Mnookin sets out to uncover the role of MMR vaccination and autism: how this belief got started, how it propagated, and how it was refuted. In the process, he explores the role of vaccines in modern society and the foibles of human thinking. When confronted with the overwhelming challenge of a child with autism, it is easy to see how feelings of the heart trump the cold process of the scientific method. Once the idea that measles vaccine and/or the preservative thimerosal could cause autism enters the popular domain, it spreads like an epidemic. That one researcher used suspect data to introduce this theory and extensive subsequent investigation only refutes it is insufficient to contain this flawed belief. In fact, reports exonerating the vaccine are perceived as attacks on the evidence of its harm and are met with hostility. The establishment (government, organized medicine, big Pharma) is perceived as covering up and defending its turf.

Problems with vaccine efficacy, side effects, and acceptance are not new. When the devastating effects of an infection such as polio are fresh in the minds of the public, glitches in vaccines are often tolerated. The irony of vaccine efficacy is that people forget those diseases and the threat of adverse vaccine effects looms greater. This makes it easier for parents to opt out of having their children vaccinated. Mnookin stresses that declining immunization rates have already led to serious outbreaks of preventable disease. However, individuals continue to crusade against vaccines and the media ~ including Oprah Winfrey ~ fans the flames of this movement. Those who are convinced



that vaccines are the cause of autism stand in the way of research into other causes and treatments. Some in the forefront profit by selling hope in the form of unproven and sometimes expensive alternative cures. But often the appeal of these charlatans begins with listening to their patients. Contrast this with a history of arrogance and condescension in the medical community and remember physicians need to keep an open mind to patients' ideas and beliefs.

Mnookin clearly lays out his case that vaccines do not cause autism and are generally safe. Like vaccine opponents, he takes advantage of dramatic human examples of the consequences of declining vaccination rates. But unlike those believers, he immediately provides good supporting data. Occasionally some of his illustrations are elegant, such as when he compares the confusion between the ethylmercury of thimerosal and methylmercury (a well-known toxin) to ethylalcohol and methylalcohol. Sometimes his examples are distracting, such as when he uses Einstein versus Newton to elucidate the scientific method. His early example of anti-rational thought such as the "birther" argument surrounding Obama may be too politically volatile to be effective, leading in my library copy to a penciled comment, "More propaganda." The book concludes with the exhaustive and clearly exonerating Omnibus Autism Proceeding. Mnookin, a new father, looks at his infant son with the hope that he will enjoy the protection that vaccines offer. *The Panic Virus* contains extensive notes, a full bibliography and helpful index.





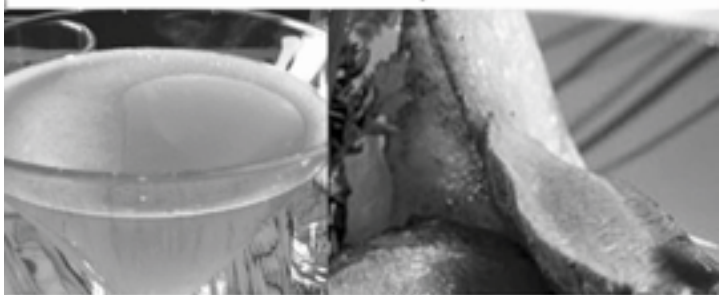
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### 22<sup>ND</sup> ANNUAL DR. A. JANE FITZPATRICK COMMUNITY SERVICE AWARD

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- 1) A letter of nomination
- 2) A current curriculum vitae of the nominee
- 3) Letters of support are encouraged

### RETURN TO:

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### FAX, PHONE OR E-MAIL

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Phone: 508-753-1579

**DEADLINE: AUGUST 6, 2012**

*Please print all information*

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Email \_\_\_\_\_ Fax \_\_\_\_\_

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